TM 8-260

WAR DEPARTMENT

TECHNICAL MANUAL

FIXED HOSPITALS OF THE MEDICAL DEPARTMENT (GENERAL AND STATION HOSPITALS)

July 16, 1941

TECHNICAL MANUAL
No. 8-260

WAR DEPARTMENT,
WASHINGTON, July 16, 1941.

FIXED HOSPITALS OF THE MEDICAL DEPARTMENT (GENERAL AND STATION HOSPITALS)

Prepared under direction of
The Surgeon General

320358°—41——1

CHAPTER 1

FUNDAMENTAL CONSIDERATIONS

SECTION I

GENERAL ORIENTATION

1. General provisions.—*a. Main classes.*—Hospitals provided by and for the Army in peace or war are divided into two main classes:

(1) Stationary or fixed (the "fixed establishments" of the Geneva Convention).

(2) Field or mobile (the "mobile sanitary formations" of the Geneva Convention).

b. Types.—(1) *Fixed hospitals.*—In time of peace or war at home or abroad, only two types of fixed hospitals are maintained for permanent or definitive hospitalization:

(*a*) Station hospitals (at times called post or camp hospitals).

(*b*) General hospitals (including those formerly called department or base hospitals).

(2) *Mobile hospitals.*—In time of actual or threatened hostilities or whenever in peace troops are in the field where fixed hospitals are not available, readily accessible, or sufficient to meet the needs, the following types of mobile units (see FM 8–5) provided for in Tables of Organization are established for temporary or emergency hospitalization:

(*a*) Clearing stations (formerly called field hospitals and hospital stations).

(*b*) Surgical hospitals (formerly called mobile hospitals).

(*c*) Evacuation hospitals.

(*d*) Convalescent hospitals (formerly called convalescent depots).

2. Designation and identification.—*a. Fixed hospitals.*—(1) *In peacetime.*—Fixed hospitals *in operation* are not given a numerical designation.

(*a*) A station hospital is identified by giving the type, title of the hospital, and its location, for example, Station Hospital, Fort Benning, Georgia.

(*b*) A general hospital is identified by giving the type, title of the hospital, and its location, and in addition thereto the name of a deceased medical officer of the Army of the United States whose services were of a distinguished character, for example, Walter Reed General Hospital, Army Medical Center, Washington, D. C.

(2) *In wartime.*—(*a*) Fixed hospitals located in the zone of the interior are designated as prescribed in (1) above.

(*b*) Fixed hospitals located in a theater of operations are designated and identified only by their number, type, and title. Their location is not given. For example, 6th Station Hospital; 110th General Hospital; 7th Veterinary General Hospital.

(*c*) Fixed hospitals bearing a numerical designation are given a number in a consecutive series from *one* upward for each type.

(3) *Names for general hospitals.*—As required from time to time appropriate names recommended by The Surgeon General for such new general hospitals as may be established in the zone of the interior are, upon approval of the Secretary of War, announced in War Department orders.

b. Mobile hospitals.—Mobile hospitals are designated by giving their number, type and title, *without location.* The number is assigned by the War Department and is consecutive for each type. For example, 2d Surgical Hospital; 5th Evacuation Hospital (see FM 8-5); 11th Veterinary Evacuation Hospital.

3. Functions and control.—*a. Fixed hospitals.*—The normal field of usefulness for fixed hospitals is in the communications zone and in the zone of the interior and *not* in the combat zone.

(1) *Station hospitals.*—A station hospital normally receives patients only from the station to which it pertains. In exceptional instances it may serve the needs of a circumscribed area, or may be designated to receive special cases from any place without a corps area or other military command under the control of whose commander it functions. A station hospital in peace or war functions under such local, district, section, or corps area control as may be prescribed by the superior commander under whose jurisdiction it is being administered.

(2) *General hospitals.*—(*a*) A general hospital is designed to serve general and special rather than local and ordinary needs. Those in the zone of the interior are located at such places as may be recommended by The Surgeon General and approved by the War Department.

(*b*) The control of general hospitals by higher authority is so arranged that it is subjected to a minimum of administrative interference in its work. Since the work of a general hospital is largely of a professional nature it has been found that the service can best be carried on untrammeled by direct military control. Within the continental limits of the United States the general hospitals function under the control of The Surgeon General, subject to the exemptions prescribed in AR 170–10. The senior medical officer on duty with a general hospital commands it and, within the continental limits of the United States, is not subject to the orders of a local commander other than the commanding general of the corps area in which the hospital is located, to whom specific authority may be delegated by AR 170–10. General hospitals in the insular possessions and those in a theater of operations function under the control of the department or tactical commanders within whose jurisdiction they may be located.

b. Mobile hospitals.—Mobile hospitals are provided to meet the needs of troops in the field or in campaign where it is impracticable to establish fixed hospitals. They also serve as relay points in the evacuation of patients to fixed hospitals where definite treatment can be given most advantageously. Their normal field of usefulness is in the combat zone. They function under the control of the tactical or territorial commander under whom they may be assigned by proper authority (see FM 8–5).

4. Purpose.—General hospitals are designed to—

a. Afford better facilities than can be provided at the ordinary station or other hospitals for the study, observation, and treatment of serious, complicated, or obscure cases. For this reason, general hospitals are equipped with the most modern apparatus and assigned especially qualified personnel.

b. Afford opportunities for the performance of the more difficult or formidable surgical operations, facilities for which may be lacking at station or mobile hospitals.

c. Study and finally dispose of cases that may have long resisted treatment elsewhere, and to determine questions of the existence, cause, extent, and permanence of mental and physical disabilities of long standing or unusual obscurity.

d. Instruct and train junior Medical Department officers in general professional and administrative duties.

e. Form the nucleus for the initial hospitalization needs of the zone of the interior in time of war.

f. Receive and give definitive treatment to patients from other hospitals in the theater of operations, particularly mobile units in the combat area.

5. Distribution and time of establishment.—*a.* General hospitals of the theater of operations are priority units in a general mobilization plan and will be established whenever the armed forces proceed to the theater of operations. The number employed in the theater of operations depends upon the proximity of the zone of the interior thereto. If these adjoin—no sea paths separating them—general hospitals are usually established in the communication zone only at the rate of one per division. Within hospitalization allowances in terms of beds, the balance needed and not allocated to the theater of operations is established in territory pertaining to the zone of the interior. (See MR 4-2 and FM 100-10.)

b. Each general hospital in the theater of operations has a normal capacity of 1,000 beds and is provided with personnel who, in emergencies and by crisis expansion under tentage, may care for 2,000 patients if the period of stress is not too prolonged. General hospitals receive cases by hospital trains, airplanes, or ambulances direct from the evacuation hospitals at the front and from other general hospitals making retrograde secondary evacuation, as well as cases originating in the communications zone. Being completely equipped from a medical and surgical standpoint they give treatment to all types of cases sent to them, forwarding to the zone of the interior only such cases as require special treatment or are not likely to be fit for service for a considerable period of time, or will probably be permanently incapacitated for further duty. However, where their capacity is being taxed or an extension of active fighting is in immediate prospect, they must either be evacuated of suitable cases or reinforced by expansion of accommodations already existing. No individual capable of further duty in the immediate future should ever be sent farther to the rear than a general hospital in the communications zone since experience has shown that the services of a great proportion of cases coming into the zone of the interior will probably be lost for the campaign if not for the war.

c. No standard capacity or equipment is prescribed for fixed hospitals in time of peace, nor ordinarily in the case of those pertaining to the zone of the interior in time of war. Their capacity and equip-

ment vary according to and are governed by local as well as general requirements.

6. Supply.—*a.* The *initial* supplies required for the establishment of a general hospital are assembled in the supply depots in the zone of the interior or the communications zone as the case may be. They may be requisitioned by the commanding officer in the form of a request for "one general hospital" when the unit is ordered to duty at the site finally selected. Tentative training equipment tables have been prepared for the use of general hospitals while undergoing training and this equipment will be left at training station sites or returned to depots as may be directed. In order to visualize the amount of supplies and equipment necessary to equip a general hospital reference is made to the following approximate figures: Net weight, 220,083 pounds; shipping weight, 324 tons; volume, 13,000 cubic feet; freight cars required, 7.3; trucks, 1½-ton, 73.3. The number of separate packages required to pack the initial supplies for a general hospital is 2,474, but if the individual items are counted the total runs up to 100,000.

b. Supplies required for the *maintenance* of a general hospital are obtained periodically on requisition by the supply officer from the Medical Department sections of the supply depots of the communications zone or zone of the interior. Certain supplies such as food stuffs may be obtained by local procurement. Special articles such as nonstandard surgical or laboratory instruments may be furnished by the American Red Cross.

7. Groupings of general hospital.—When possible two or more general hospitals with a convalescent camp (capacity of 1,000) are grouped together under an overhead known as the hospital center. This arrangement has the advantage of economy of administration, and offers the opportunity for specialization and pooling of transportation facilities. From an administration point of view, it is highly desirable to pool or otherwise centralize such features as quartermaster and medical supplies, laundries, bakeries, water transport, power, heat, military police, and fire prevention. Professionally, the hospital center is advantageous in that it permits the special assignment of one general hospital to any desired specialty or group of cases.

SECTION II

ORGANIZATION OF GENERAL HOSPITAL

8. Basis and divisions.—The general organization of numbered general hospitals is in conformity with T/O 8-507 and with provisions of AR 40-590. The organization falls naturally into three divisions, the headquarters, the administrative, and the professional services. The two services are not subordinate command elements but rather a grouping of elements possessing related functions. The chain of command is from the hospital commander directly to the commander of the separate functional elements of the two major services.

9. Headquarters.—The headquarters consists of the unit commander, the senior officer of the Medical Corps assigned and present for duty (see par. 10), his staff (see par. 11), and the personnel necessary to assist in the general administration of the unit and its installation.

10. Commanding officer.—*a.* The commanding officer of a general hospital is responsible for its proper discipline and administration, including the care and preparation of the necessary reports, registers, and records, as well as for the care and safeguarding of all Government property that may come into his possession, for the proper expenditure of supplies and funds, and for the preparation of requisitions, returns, and pay rolls of the hospital. While the commanding officer is not charged with the execution of duties properly delegated by him to an assistant, yet he is responsible for exercising such supervision over duties thus delegated as to insure their prompt and efficient performance by the designated subordinate. The responsibility of the commanding officer for the action of his assistants is something that must always be borne in mind. At the same time, the commanding officer must not exercise this supervision to the extent of operating a functional element that has been assigned to a subordinate.

b. The commanding officer is responsible for the military and technical training of all elements of his command. He must—

(1) Insure the attainment of proper training objectives prior to the time his unit goes to the theater of operations.

(2) Establish policies regarding the various procedures involved in the establishment and operation of the hospital, and assign appropriate personnel to the various divisions (see app. II).

11. Unit staff.—*a. Executive officer.*—The executive officer is charged under the direction of the commanding officer with the co-

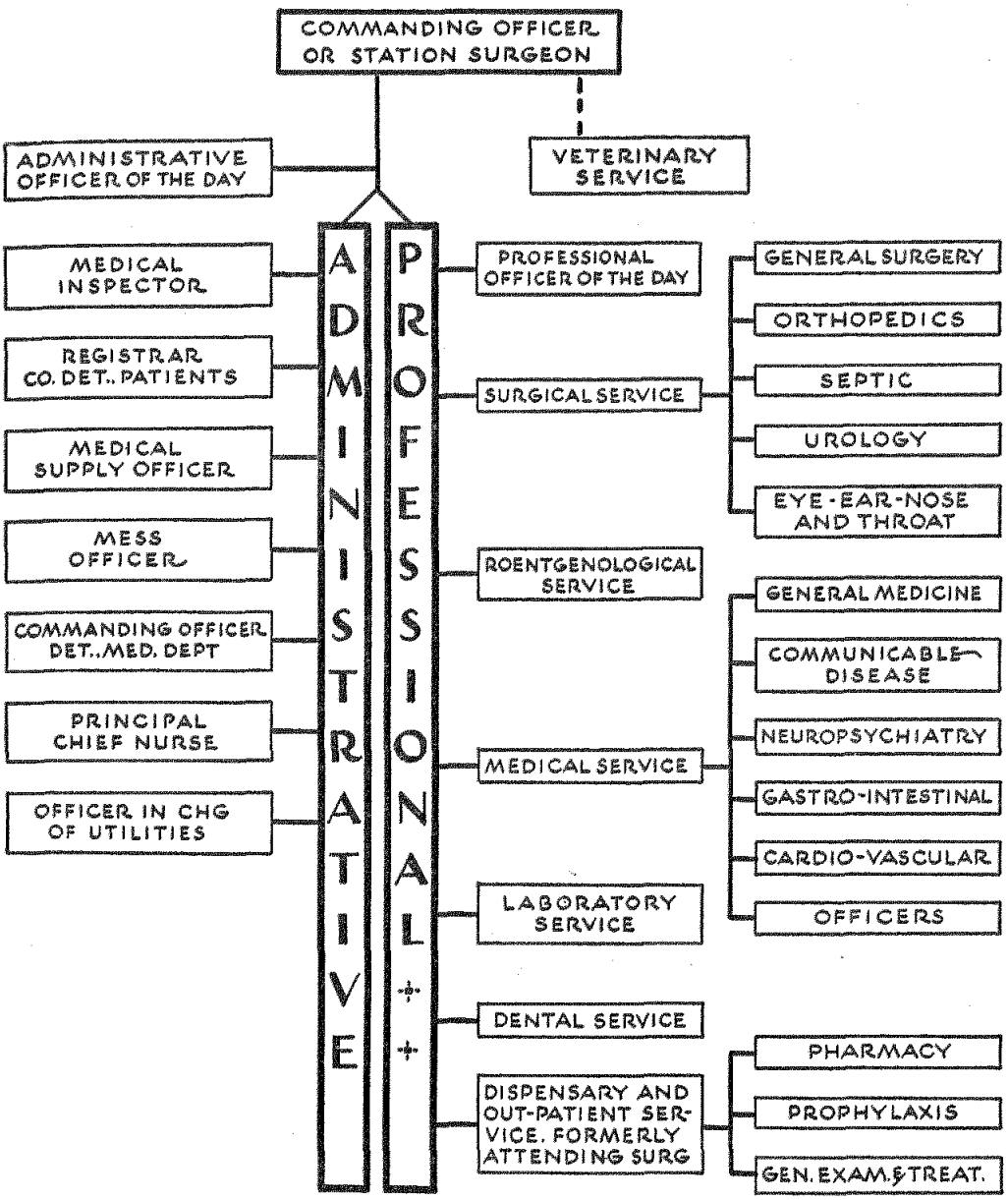


FIGURE 1.—Organization of a hospital (to be used as a guide only).

ordination of all activities of the hospital and such additional duties as may be prescribed by the commanding officer. All questions arising in the hospital on which a decision must be rendered, unless they are of a major character or are ones of policy, are decided by the

executive officer in the name of the commanding officer. Until the executive officer is thoroughly conversant with the policies of the commanding officer, all questions should be submitted to the commanding officer if there is any possibility of doubt as to what his desires in the matter may be. The decision of the commanding officer is final and the executive officer must carry it out. Loyalty must always be the keyword of this position.

b. Adjutant.—The adjutant performs the duties of his office as prescribed in AR 90–50 (see also FM 101–5). He has charge of civilian employees and is responsible for the proper operation of an office for information. He has charge of all incoming and outgoing correspondence, orders, circulars, and has general control of all hospital records. He verifies and issues all orders and details, including administrative assignments both special and by roster of officers and civilian employees. He should keep a check on the audit of all public funds and submit a report of audit, together with a statement of all funds to the commanding officer as soon as possible after the end of each month.

c. Medical supply officer.—The medical supply officer is charged with the procurement, storage, and issue of all medical supplies at the hospital, and is accountable for all medical property, except where other accountability is specifically designated by proper authority. He submits the required requisitions, etc., and maintains the necessary property and other records pertaining to his office which may be required by existing regulations. (See AR 40–1705. See also pars. 51–60 and app. IV.)

d. Chaplain.—See TM 16–205.

e. Personnel officer.—The personnel officer is the assistant adjutant and is charged with the administration of all personnel matters except those retained by the medical detachment and the detachment of patients (see AR 345–5). It is suggested that the lieutenant, Medical Administrative Corps, in the registrar and detachment of patients section be charged with this office. Collectively, his clerical assistants are designated the unit personnel section and are furnished from the detachment Medical Department, supplemented if necessary by personnel of the unit headquarters.

12. Administrative service.—*a. Registrar.*—The registrar performs the duties outlined in AR 40–590 and such additional duties as may be prescribed by the commanding officer. He has charge of sick and wounded records and reports. He exercises administrative jurisdiction over all matters pertaining to deaths, casualty reports, and disposition of remains, and makes such reports in con-

nection therewith as may be required by existing regulations (AR 40–1025). He prepares the necessary notification to the nearest relative or friend of casualties within the hospital.

b. Director of dietetics.—The director of dietetics has charge of and is responsible for the administration of all that pertains to the hospital messes. He is the custodian of the hospital fund and as such is responsible that it is administered in accordance with existing regulations (see pars. 22–41, and app. V).

c. Commanding officer, detachment of patients.—The commanding officer, detachment of patients, exercises immediate command over all patients and has charge of all records, reports, and correspondence pertaining thereto. He also has charge of all money and valuables belonging to patients. He is, in addition, in charge of the patients' baggage room (see pars. 83–90 and 108–115).

d. Commanding officer, medical detachment.—The commanding officer, medical detachment, exercises immediate command over all enlisted personnel in the Medical Department on duty at the hospital, supplying such details, temporary or permanent, to different wards or departments of the hospital as may be required. He is responsible for the discipline, training, equipment, uniform, and quartering of all men of his detachment (see pars. 116–122 and app. VI).

e. Receiving and disposition officer.—The receiving and disposition officer is responsible for the admission and disposition of all patients to and from the hospital. He receives, examines, classifies, and sends to the proper wards all incoming patients, exercising due care and precaution in the prompt isolation of all communicable diseases. He keeps informed at all times concerning the number of beds available in the various wards and foresees and provides for expected arrivals. He supervises the transportation of sick or wounded to and from the hospital. He temporarily receives and safeguards the money and valuables of incoming patients and receives and receipts for the baggage of patients prior to release to commanding officer, detachment of patients. He prepares all required forms, records, and notifications in connection with the admission of patients. He makes all arrangements for patients leaving the hospital. When a convoy of patients is being evacuated from the hospital, he should check the convoy by name and see that necessary records and papers are complete and go with the shipment (see pars. 40–50).

f. Principal chief nurse.—The principal chief nurse has general supervision over all Army nurses on duty at the hospital, arranges the hours of duty, their assignment, has supervision over their messes,

and is responsible for their discipline both on and off duty. She brings to the attention of the commanding officer any serious breach of discipline on the part of a nurse or other occupant of the nurses' quarters. The principal chief nurse is in charge of the nurses' quarters, the property contained therein, is responsible for the comfort and well-being of the nurses under her, and for the proper keeping of the necessary records pertaining to Army nurses (see pars. 199–204 and app. VII).

g. Hospital inspector.—The hospital inspector acts as medical inspector of the hospital (AR 40–270), and makes such routine and special inspections and investigations as may be prescribed by the commanding officer. He makes a monthly check of all alcoholics, narcotics, and habit-forming drugs in the pharmacy and in the hands of the medical supply officer, reporting the fact of inspection and existing irregularities to the commanding officer. He inspects and checks, once each month, the narcotic books in all wards and departments, noting facts and dates of inspection immediately after the last entries in the books. In conformity with the provisions of paragraph 10*d*, AR 210–10, he makes an inventory at least once a month of such articles in the hands of accountable and responsible officers as may be designated by the commanding officer, and upon completion thereof reports the fact of inventory and irregularities so discovered to the commanding officer. He makes frequent inspections of all offices and departments of the hospital to insure that the regulations governing their operations are on file and are being complied with (see app. I).

13. Professional service (see ch. 3).—*a. General.*—(1) The professional service represents a grouping of certain functional elements of the hospital and is *not* an organic element of the unit. Normally, each service, medical, etc., is an independent element of the hospital and the chief thereof directly responsible to the unit commander. The commander may subordinate certain auxiliary service(s) to one of the major services. For example, the physical therapy section may be placed under the command of the chief of the medical or surgical service. These are decisions for the unit commander and do not change the various functions of the services involved.

(2) The professional service is responsible for the care and treatment of *all* patients admitted to the hospital from the time they are relinquished by the receiving and disposition officer until they are returned to duty or turned over for transfer to a convalescent or another general hospital. The professional service is

the basic functional element of the unit, and the headquarters and the administrative service merely furnish those aids necessary to permit the execution of appropriate procedures by that service.

b. Services.—The professional service is normally made up of five principal services as follows:

(1) *Medical service.*—The medical service is made up of six sections as follows:

(*a*) Gastroenterology.
(*b*) Neuropsychiatry.
(*c*) General medical.
(*d*) Cardiovascular.
(*e*) Communicable disease.
(*f*) Officer's.

(2) *Surgical service.*—The surgical service is made up of five sections as follows:

(*a*) Orthopedic.
(*b*) Urologic.
(*c*) Eye, ear, nose, and throat.
(*d*) Septic surgery.
(*e*) General surgery.

(3) *Laboratory service.*—See paragraphs 177–183.

(4) *Roentgenological service.*—See paragraphs 184–188.

(5) *Dental service.*—See paragraphs 189–198.

c. Chief.—All of the above-mentioned professional services are under charge of an officer who is known as the chief of service. Each section is under the charge of an officer known as chief of ——— section. Chiefs of services are responsible directly to the commanding officer for the administration of their service, and chiefs of sections are responsible to the chiefs of service for the administration of their sections. The chiefs of services act as consultants in the hospital. Each service keeps a record of patients treated as out-patients and submits appropriate information to the registrar for "card for record" in all cases where the condition may have a future bearing on the case. (See AR 40-1025.)

14. Training.—*a. Responsibility.*—The unit commander is responsible for all training.

b. Management.—Since there is no plans and training officer on the unit staff, the actual management of *individual* training devolves upon the detachment comander. Acting within the policies and directives of the unit commander and subject to the latter's approval, he prepares the unit training programs and schedules, assigns instructors, and exercises general supervision. The unit commander in turn makes

such training inspections as he deems necessary to insure the proper progress of training and attainment of the prescribed objectives. *Group* training is managed by the section and service commanders; unit training by the unit commander.

c. Individual.—See appendix, FM 8-5.

d. Specialist.—See appendix, FM 8-5.

e. Unit.—All phases of training are important to the general hospital but none is so vital as the unit training. The equipment and varied duties demand the systematic and coordinated functioning of all elements if the whole is to act as one body.

SECTION III

ESTABLISHMENT OF GENERAL HOSPITAL

15. Selection of sites.—*a.* The distribution of general hospitals in the communications zone is planned by advance studies of the theater of operations. The chief surgeon, GHQ, selects the sites in conformity with GHQ policies and after consultation with the assistant chief of staff, G-4, GHQ.

b. In locating general hospitals in the communications zone, the guiding consideration is to have them established on or immediately off the main arteries of railway traffic and preferably on those radiating from a regulating station serving the forces at the front. General hospitals should be echeloned from front to rear. Within the communications zone a certain number, depending upon the size of the whole force, should be located as near the troops they are intended to serve as is warranted by considerations of security and ready access by hospital train, bus, airplane, or ambulance.

c. The establishment of a general hospital creates a heavy demand for shelter. This is provided either by taking over existing buildings such as schools, hotels, barracks, industrial plants, and former hospitals, or by new construction. Tentage will rarely be used except for the purpose of crisis expansion. When buildings are taken over for hospital purposes many alterations, additions, and repairs are usually necessary to render them habitable and suitable for the work. Whenever temporary construction is undertaken it must be of the simplest standardized type. This becomes readily obvious since a general hospital consists of approximately 62 buildings: 33 wards, administration, surgical, receiving and forwarding and bath buildings,

messes, and the usual personnel buildings and detached latrines and baths. The ward buildings should be identical with exceptions noted in paragraph 16. Expensive fixed installations and major items of nonstandard equipment, sewerage, water mains, private rooms, large cooking equipment, etc., must be held to the minimum with the object of reducing time and cost on both construction and abandonment. (See fig. 2.)

d. To economize in heating and lighting and structural material the buildings are grouped as closely as consideration of fire safety permits. In the lay-out of a general hospital unit, a vacant space is always left at the outer end of each ward for the erection of tentage in emergencies to meet the so-called crisis expansion needs. When this crisis expansion is being employed the more serious cases are retained in the ward proper and the slighter or ambulant cases graduated from day to day into the tented section of the ward.

16. Buildings.—Housing facilities for the sick in general hospitals of the zone of the interior when newly constructed should provide—

a. Wards.—(1) *Combination.*—The combination ward has 26 beds, 10 private (6 with private bath) and 16 open with adjoining toilet separate from adjoining bath and lavatory; patient's clothing and baggage room; utility room; serving kitchen; linen room and nurses' toilet; office; examining room; open porch and glassed-in solarium. Wards of this type provide for seriously ill, isolation, and segregation. As the size of the hospital increases above 500 beds, the proportion of combination wards is reduced and standard type wards predominate with two detention type wards.

(2) *Standard.*—The standard ward has 33 beds, 2 semiprivate and 31 open with adjoining toilet separate from adjoining bath and lavatory. Offices and utilities are otherwise the same as the combination ward. These buildings are intended for the noncontagious and convalescent patients.

(3) *Detention.*—The detention ward has 25 beds, 9 private (4 with private bath) and 16 open with adjoining toilet separate from adjoining bath and lavatory; patients' clothing and baggage room; utility room; serving kitchen; linen room and nurses' toilet; office examining room, and two wire-meshed porches. These buildings are intended for closed N. P. cases and prisoners.

(4) *Number.*—In a general hospital of 1,000 beds there will usually be 10 combination, 21 standard, and 2 to 4 detention type wards.

b. Personnel.—Both officers' and nurses' quarters should be extensible buildings. Accommodations should consist of simple 1- and 2-bed rooms, common toilets and showers, and a common living room

in all buildings. The medical detachment is housed in barracks on the basis of 125-man blocks. A 250-man block consists of four barracks (63-man capacity with inside lavatories), one mess hall, one recreation building, and one administration and supply building. For units such as a general hospital with a 500-man detachment, a variation of the standard block is provided such as a 500-man mess hall of special design and additional 63-man barracks.

o. Messes.—(1) In a general hospital it is necessary to have at least three messing units, one for enlisted detachment, one for all commissioned personnel, and one for enlisted patients. Seating arrangement must be such as to permit necessary or desirable expansion. In estimating the basic messing requirements, the following assumptions may be made:

(*a*) 10 percent of hospital beds may be occupied by officers and nurses.

(*b*) 50 percent of enlisted sick may walk to mess hall.

(c) 50 percent of officers and nurses may walk to mess hall.

(*d*) 3 percent of medical detachment and 4 percent of nurses will be sick in hospital.

(2) Messing requirements in a 1,000-bed hospital are as follows:

Mess	*Kitchen, cooking capacity*	Mess hall
Enlisted patients (plan I–2) For enlisted sick, 1,000 −100=900.	Required, 900 Provided, 1,000	To mess hall 900−450=450. Seating capacity=304. Cafeteria service, rate per hour=900. Serving time=30 minutes.
Medical detachment (Plan I). 500−15=485	Required, 485 Provided, 500	To mess hall=485. Seating capacity=240. Cafeteria service, rate per hour=300. Serving time=1 hour, 37 minutes.
Commissioned (Plan I–11) For duty officers, 73 For duty nurses, 120 For commissioned sick, 100 293	Required, 293 Provided, 275	To mess hall 73+(120–5) +(100–50)=238. Seating capacity=192. Cafeteria service, rate per hour=240. Serving time=1 hour.

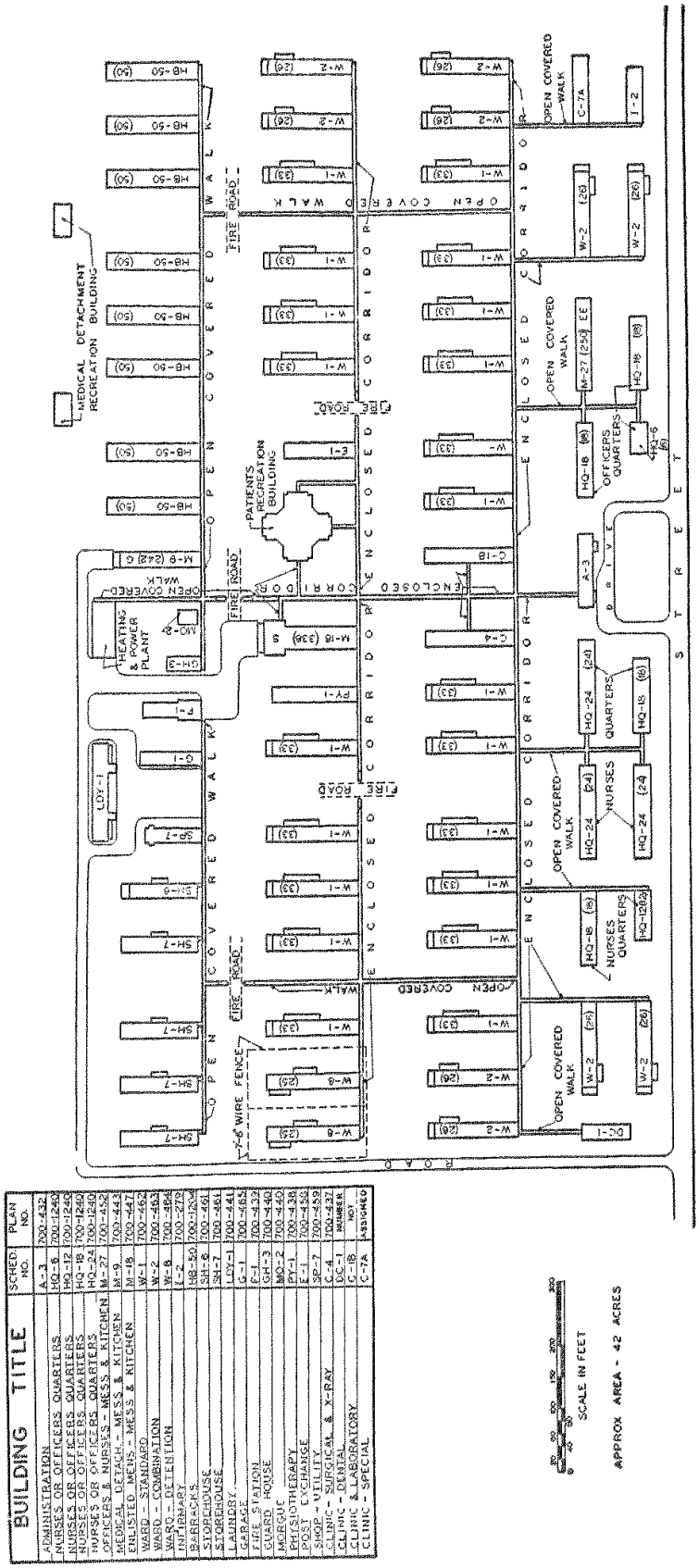
d. Administrative and professional.—In hospitals up to 250 beds administrative, professional, and technical work are provided for in one large central administrative building. At 1,000-bed hospitals all three functions, administrative, professional, and technical, have separate buildings. Provision for reception and forwarding of the sick is made in the administrative building with separate entrance and exit. Reception as now contemplated does not include initial bath, clothing change, storage, or observation wards. Provision is made for reception, including all records, collection of valuables, and ward assignment. Initial bath, issue of hospital clothing, and storage of patient's clothing are provided in each ward. Thus decentralized individual attention may be given at once and with less effort by any one group; confusion is reduced and clothing properly stored in each patient's ward is always at hand.

17. Lay-out.—The lay-out of buildings shown in figure 2 should be followed if local terrain permits. It is considered the most suitable for satisfactory operation. At places where the local terrain does not permit adherence, local authorities will prepare new lay-outs made in accordance with at least the following three of the fundamentals which govern all lay-outs:

a. Buildings having to do with all sick, that is, main mess, surgery clinics, administrative buildings, etc., are centrally located.

b. Ward housing principally for the ambulant who, if near enough, can walk to the above facilities, that is, standard wards, form the first concentric building group immediately surrounding the central group.

c. Wards housing communicable diseases, the segregated, the seriously ill requiring quiet, and others unable to walk to the central facilities referred to, that is, combination wards, form the next or outer concentric building group.



BUILDING TITLE	SCHED. NO.	PLAN NO.
ADMINISTRATION	A-3	700-432
NURSES OR OFFICERS QUARTERS	HQ-8	700-1245
NURSES OR OFFICERS QUARTERS	HQ-12	700-1245
NURSES OR OFFICERS QUARTERS	HQ-24	700-1240
NURSES OR OFFICERS QUARTERS	W-27	700-452
OFFICERS & NURSES MESS & KITCHEN	M-9	700-443
MEDICAL OFFICERS - MESS & KITCHEN	M-18	700-447
ENLISTED MEN'S - MESS & KITCHEN	W-1	700-462
WARD - STANDARD	W-2	700-463
WARD - COMBINATION	W-8	700-484
WARD - DETENTION	E-2	700-279
INFIRMARY	HB-50	700-1204
BARRACKS	SH-8	700-461
STOREHOUSE	SH-7	700-461
STOREHOUSE	LDY-1	700-441
LAUNDRY	G-1	700-462
GARAGE	E-1	700-432
FIRE STATION	GH-3	700-440
GUARD HOUSE	MO-2	700-440
MORGUE	PY-1	700-438
PHYSIOTHERAPY	E-1	700-458
POST EXCHANGE	SP-7	700-459
SHOP - UTILITY	C-4	700-437
CLINIC - SURGICAL & X-RAY	DC-1	700-437
CLINIC - DENTAL	C-18	ASSIGNED
CLINIC & LABORATORY	C-7A	ASSIGNED
CLINIC - SPECIAL		

Figure 2.—Building lay-out, typical 1,000-bed general hospital.

CHAPTER 2

ADMINISTRATIVE PROCEDURE

SECTION I

GENERAL

18. General.—The administrative procedures outlined herein are basic and somewhat in detail. The procedures should serve as a guide for unit administration and be modified to meet the varying conditions with which the unit may be confronted.

SECTION II

INFORMATION OFFICE

19. Organization.—The information office for the purpose of administration is under the adjutant. A noncommissioned officer is detailed in charge with such enlisted assistants as may be necessary. This office is kept open 24 hours each day.

20. Function.—The functions are—

a. Index of patients.—In order that a ready reference may be available, a Kardex card is prepared for each and every patient admitted. Care is exercised that all the data recorded are correct. These cards are filed alphabetically according to last name in dictionary index order. Any change in wards or other data are noted immediately on this card. These cards remain in the "live file" until the patient is returned to duty, discharged, dies, or is otherwise disposed of, when the card is filed in a "dead file" in the same manner as prescribed for the live file where it is kept for 3 months for reference.

b. Rosters of duty personnel.—A roster of duty personnel, military and civilian, is kept up to date for reference.

c. Roster of seriously ill patients.—A roster of patients who have been reported as seriously ill is kept and no name will be removed until a death notice has been received, or on the request of the commanding officer, detatchment of patients, who is responsible that no patient who has been reported as seriously ill remains on the roster after recovering sufficiently to warrant the removal of the name from the list.

d. Information given out.—All information requested is given freely, except that in no instance is diagnosis furnished. Requests for diagnosis are referred to the adjutant or the executive officer.

e. Packages, telegrams, special delivery letters, etc.; received.—All packages, telegrams, special delivery letters, flowers, etc., received for a patient who is in the hospital, are receipted for, entered in a book provided for this purpose, and delivered to the patient with the least practical delay. Receipt from the patient or the nurse in charge of the ward is obtained in this book.

f. Function under administrative officer of the day.—During the hours that the administrative offices of the hospital are closed, the personnel perform such duties in and about the hospital as may be directed by the administrative officer of the day as well as any clerical work that may be required.

g. Telegrams.—A book is maintained in the information office with a copy of the standard forms for routine telegrams which must necessarily be transmitted during hours that administrative offices of the hospital are closed. All telegrams sent out during these hours conform to the appropriate form indicated in each case. Replies to all telegrams, except official business, are sent *collect.*

21. Report of administrative officer of the day.—The report of the administrative officer of the day is prepared in the infor-

mation office. All changes in duty personnel are recorded under the appropriate heading.

SECTION III

DIETETIC DEPARTMENT

22. Organization.—All messes at the hospital are under the immediate supervision of an officer designated by the commanding officer, who is known as the "director of dietetics" (mess officer). He may delegate the direct supervision of the nurses' mess to the principal chief nurse who is responsible for all activities pertaining to it. He has such commissioned assistants, dietitians, and civilian employees as the commanding officer may designate (par. 17*b* and *d*, AR 40–590). Ward diet kitchens to which a dietitian is assigned to duty function under the direct control of the director of dietetics who is responsible for their police, sanitation, and efficient operation. He is also responsible for the property pertaining thereto. Ward diet kitchens in which a dietitian is not assigned to duty function under the direct control of the ward officer.

23. Director of dietetics.—The director of dietetics has charge of and is responsible for the general administration of all messes in the hospital. He will comply with paragraph 17, AR 40–590. He is the custodian of the hospital fund, and as such is responsible that it is expended in accordance with existing regulations (par. 17, AR 40–590 and AR 210–50). He is charged with the responsibility for the selection, purchase, care, storage, issue, preparation, and serving of all food supplies. He sees that the equipment for the handling and serv-

ing of food is sufficient, clean, and properly cared for. He has charge of the police and sanitation of the department. He assumes property responsibility unless the commanding officer directs otherwise. He may delegate any of his duties to a commissioned assistant who is responsible to him for the proper execution of such delegated duties.

24. Chief dietitian.—The chief dietitian, under the director of dietetics, is responsible for the entire food service to all patients and others authorized to mess at the hospital. She must submit bills of fare for all patients to the director of dietetics for approval. She maintains supervision over the dietitians under her charge and is directly responsible for their conduct and efficiency. She assigns them to specific duties and holds them responsible for the proper performance thereof. She makes recommendations to the director in regard to purchases of food supplies and mess equipment.

25. Records.—The following records are maintained by the director of dietetics:

a. Stock cards.—For all articles in stock, cards are prepared and purchases and issues are noted thereon.

b. Inventory list.—The inventory list is completely itemized to show all articles of food remaining on hand in the storeroom at the end of each month, together with the money value and total cost.

c. Monthly statement of cost.—In this book are recorded the cost of operating each mess, the total number fed during the month, and the cost per capita.

d. Bills of fare.—Bills of fare are prepared daily. Signed copies are furnished the commanding officer, wards, kitchen, and dining rooms.

e. Mess account.—Daily transactions of the mess are accounted for on the Mess Account (W. D., M. D. Form No. 74) for each mess, and a consolidated account is kept on this form for the entire dietetic department.

f. Hospital fund statement.—The hospital fund statement is prepared monthly in accordance with AR 210-50. Retained copies of the hospital fund statement and mess account, with pertinent vouchers, are filed with the records of the mess.

g. Cash book.—A cash book is kept of all cash receipts, and shows the source and disposition.

h. File of patients' receipts.—A duplicate of the receipts furnished all pay patients upon payment of their accounts.

i. Record of pay patients.—A card is kept for each pay patient in the hospital showing the name, status, date of admission, date of discharge, rate of charges per day, date payment for subsistence and medicine

charges was made, and the amounts for subsistence and for medicine separately. This record is maintained in two files:

(1) A file consisting of patients in the hospital and unpaid accounts.

(2) A file consisting of those discharged from hospital and accounts paid.

j. Records of durable property.—All durable property belonging to the Hospital Fund is entered on Stock Record Cards (W. D., Q. M. C. Form No. 424), showing the date, voucher number, and quantity. A memorandum receipt is prepared by the director of dietetics and signed by the person holding the property and filed with the stock record cards. An abstract of these receipts is kept on Account of Property on Memorandum Receipt (W. D., Q. M. C. Form No. 488), showing the location of each article of durable property. Transfers of responsibility are made whenever custody of property changes.

k. Bank account.—The bank account comprises deposit books, canceled checks, retained stubs, and bank statements.

26. Subsistence, medicine, and miscellaneous charges.—The director of dietetics makes collection of all subsistence indebtedness due the hospital fund by pay patients, and is responsible for the proper maintenance of all accounts and records pertaining thereto. He also receives, accounts for, and disposes of all funds paid as medicine and miscellaneous charges by patients in hospital who are not entitled to care and treatment at the expense of Army appropriations. He renders a statement to pay patients on the last day of each month showing the patient's indebtedness, and when paid he furnishes an itemized, numbered, and signed receipt. All patients remaining in hospital on the last day of the month are required to pay their indebtedness in full before the fifth day of the following month. In all cases where patients desire to make payment and are physically unable to leave their ward, the ward officer arranges for the prompt payment of their bills to the director of dietetics. All other patients are required to make their payment at the office of director of dietetics. Pay patients who are discharged from the hospital pay their indebtedness on the day of their departure. The director of dietetics institutes the necessary steps in accordance with Army Regulations for the collection of moneys due the hospital fund by pay patients for which settlement cannot be obtained.

27. Purchase of food supplies.—The director of dietetics, or his commissioned assistant, personally makes all purchases of food supplies required by the messes. He assures himself that the supplies charged to the hospital fund are actually received, safely stored, and issued for proper use. He maintains an accurate record of sup-

plies received and of those issued to the various messes. All components of the ration of the organization mess are purchased from the quartermaster when such components are available.

28. Night cook.—The director of dietetics details a night cook from the personnel assigned to him. The night cook is on duty from 6:00 PM to 4:30 AM, at which time he is relieved by the day cook. He remains awake and does not leave the mess during his tour of duty. He prepares the night meal for the men on night duty. He will not allow anyone in the kitchen except the personnel actually on duty. The night personnel, including enlisted men, nurses, and members of the guard, are served in the dining room designated for that purpose between 11:00 PM to 12:30 AM. No persons not actually on duty are served unless authorized by proper authority. The night cook allows no property, supplies, or subsistence stores to be taken from the mess during his tour of duty, and reports any unusual occurrences to the administrative officer of the day and to the director of dietetics.

29. Payment for supplies.—The director of dietetics makes payment for all supplies purchased and obtains a receipt therefor.

30. Bank deposits.—The director of dietetics deposits in the authorized bank to the credit of the hospital fund, ——— General Hospital, all moneys received. He is authorized to keep a small amount of cash on hand with which to make change for pay patients in the settlement of their indebtedness.

31. Meals.—*a. Promptness.*—Meals are served promptly at the prescribed hours, exceptions to be made only upon proper authorization.

b. Hours.—The hours for serving meals in the various messes of the hospital are prescribed from time to time in memorandum orders.

32. Food handlers.—The director of dietetics is responsible for the observance of AR 40–205 governing the examination of permanent food handlers.

33. Inventory of supplies.—The director of dietetics, or his commissioned assistant, makes a physical inventory of all supplies on hand on the last day of each month, and enters the quantity of each item, unit cost, value of each item, and the total value on the inventory list.

34. Property responsibility.—The director of dietetics is responsible for all supplies. On the first day of each month the director of dietetics, or his commissioned assistant, causes a physical check to be made of all property for which he is responsible. On

completion he reports the results to the accountable officer. Shortages which cannot be adjusted will be surveyed without delay.

35. Cafeteria system.—All enlisted duty personnel and patients on an enlisted status who are on a regular diet and whose condition permits are served by the cafeteria system. Patients whose physical condition is such as to preclude being served this way receive table service. The director of dietetics provides a sufficient number of tables and properly trained attendants for such patients.

36. Messes.—*a. Patient officers.*—The director of dietetics causes a separate mess to be maintained for all patients on an officer status. Ambulant patients on an officer status on regular diets should be furnished table service.

b. Nurses.—(1) The nurses' mess is a part of the dietetic department, and functions normally under the delegated authority of the principal chief nurse. She is responsible for the selection, purchase, storage, issue, preparation, and serving of food for this mess. All bills contracted by her must be sent promptly to the custodian of the hospital fund for payment. She may receive reimbursement for cash purchases made by her, or an authorized assistant, by forwarding the receipt with a letter of transmittal to the custodian of the hospital fund.

(2) A member of the Army Nurse Corps may be detailed in direct charge of the mess. This nurse may personally make purchases of supplies required or may request that they be made through the director of dietetics. She is responsible for their economical use. She checks the daily bills and keeps records of all her transactions. She directs and is responsible for the work of the employees in the kitchens and dining rooms.

(3) Army nurses, special nurses, dietitians, physical therapy aides, and such other employees as may be authorized are subsisted in the nurses' mess. At the end of each month or upon departure from the hospital by reason of transfer, leave extending over the end of the month, etc., Army nurses, special nurses, physical therapy aides, and all others subsisted at the nurses' mess, pay into the hospital fund for each day they have been furnished meals the amount prescribed in Army Regulations. A statement showing clearly the amounts due from the above groups, number of days, per diem rates, and amount of credit allowed for mess attendants subsisted in the nurses' mess is submitted to the director of dietetics by the principal chief nurse at the end of each month, together with the vouchers to be paid by him. The total amount of the vouchers will not exceed the total amount of credits.

(4) Hours for meals in the nurses' mess are prescribed by the principal chief nurse.

37. Nurses' funds.—*a.* Funds accruing to the nurses' mess from commutation of rations, donations from guests, messing charges from aides, technicians, and other civilian employees may be used to provide means for contributing to the welfare, comfort, pleasure, contentment, and physical and mental improvement of the members of the nurses' mess.

b. The custodian of the hospital fund keeps a record of all funds accruing from this source and keeps the principal chief nurse informed of the amount available for recreational and other purposes as indicated in *a* above.

c. The principal chief nurse may procure, within the limits prescribed by AR 210–50, such articles as may be required for the purposes mentioned above, submitting the bills therefor to the custodian, hospital fund, or, if she prefers, may purchase the articles, secure receipt therefor, submit them to the director of dietetics and secure reimbursement for the amount so expended. When such action is taken, request for payment or for reimbursement is made.

38. Responsibility of ward officer.—Nothing in this manual will be interpreted as preventing the ward officer from making periodical inspection of the food served to patients, the appearance of trays, etc. Such inspections will be made at frequent intervals and irregularities or defects which may be found to exist reported immediately to the director of dietetics.

39. Hospital council.—*a.* The hospital council consists of the three senior officers present and on duty with the unit to which the fund pertains.

b. The hospital council is governed by the provisions of AR 210–50.

Section IV

RECEIVING AND DISPOSITION OFFICER

40. Function.—The receiving and disposition office is under the immediate supervision of an officer of the Medical Corps who is designated as the receiving and disposition officer. During his absence from the office his duties are assumed by the medical officer of the day. The admission and disposition of all patients are accomplished through the receiving and disposition office. The ambulance service at the hospital is regulated by the receiving and disposition officer.

41. Receiving and disposition officer.—The receiving and disposition officer is responsible for—

a. Admission of all patients to hospital.

b. Final discharge of patients from hospital.

c. Regulation of the ambulance service provided by the hospital.

d. Preparation and rendition of prescribed reports and forms pertaining to his office.

e. Strict observance of regulations governing funds, money, and valuables of patients upon their admission to hospital.

f. Proper care and medical treatment of patients from the time of their arrival in the receiving and disposition office until the professional officer of the day or the ward officer has assumed charge of the case.

g. Admission of only those patients to the hospital who are entitled to treatment according to Army Regulations or whose treatment is authorized by the Secretary of War. Only in extreme necessity will persons not entitled to admission to Army hospital be admitted. (For list of persons entitled to treatment see paragraph 6, AR 40-590.)

h. Deposit of sufficient funds in special cases to cover hospital charges.

42. Admission of patients.—*a. General.*—(1) All patients are admitted through the receiving and disposition office, where the required admission data are made of record an assignment to a proper ward effected. In emergency the patient may be taken direct to the ward and the necessary admission data obtained later.

(2) Patients reporting for admission are examined and placed in a ward without delay.

(3) Patients with communicable diseases arriving by ambulance are not permitted to leave the ambulance or enter the receiving and disposition office, but after being seen by the receiving and disposition officer are sent direct to the communicable disease section. Ambulatory patients with communicable disease reporting to the receiving and disposition office are conducted by the shortest way to the communicable disease section by an orderly who will prevent the patient from coming in contact with other patients.

(4) The receiving and disposition officer in the case of each patient admitted to hospital sees that he is admitted to the proper ward for treatment.

(5) When insane cases or prisoners are admitted, their attendants or guard escort them to the proper section or ward accompanied by an orderly from the receiving and disposition office.

(6) Patients admitted to the hospital are conducted to the proper ward by an orderly who, in all cases, carries any baggage the patient may have.

b. Baggage.—Patients admitted from trains or boats are asked by the receiving and disposition officer whether or not they have baggage other than that which accompanied them at the time of admission. If so, they are requested to deliver the checks to the receiving and disposition officer. (See pars. 109 and 112.)

c. Arrival by boat or rail.—The receiving and disposition officer provides the necessary ambulance service and attendants for patients arriving by boat or rail. When he is advised that a number of patients will arrive he makes preparations in advance for their reception and admission to wards. When patients are scheduled to arrive at hours other than those scheduled for the receiving and disposition officer, the latter arranges for the necessary transportation and attendants, and advises the medical officer of the day accordingly. The receiving and disposition officer takes measures to assure that separate ambulances are provided for communicable diseases.

43. Discharge of patients.—*a.* The final discharge of patients is accomplished as directed in paragraph 70.

b. A record of all discharges from the hospital is entered by the receiving and disposition officer on the admission and departure sheet, the data therefor being obtained from the disposition slips of discharged patients. After entry has been made the disposition slip is transmitted to the registrar for permanent file.

44. Evacuation of patients by boat or rail.—The receiving and disposition officer is responsible for the proper evacuation to train or boat of all patients transferred to other hospitals, their homes, or elsewhere. He familiarizes himself with the details of the evacuation and is responsible for its conduct until the patients and attendants are actually on the boat or train. Attendants detailed to accompany patients report to the receiving and disposition officer in advance of their departure for instructions regarding their specific duties. Patients to be transferred without attendants report to him for instruction. In either event he provides the necessary local transportation. In the case of evacuations scheduled for hours when the receiving and

disposition officer is off duty, he advises the medical officer of the day and informs him of the details for the evacuation.

45. Inspection of enlisted men returned to duty.—The commanding officer, detachment of patients, inspects all enlisted men returned to duty from the hospital and sees that none are permitted to leave in improper uniform. Particular care is taken that no patients are permitted to leave for a colder climate without adequate clothing.

46. Notification of patient's arrival.—The noncommissioned officer or clerk on duty at the time of arrival of a patient for admission to hospital immediately notifies the receiving and disposition officer or in his absence, the medical officer of the day.

47. Ambulance service.—Ambulance service at the hospital is furnished under the direction of the receiving and disposition officer or in his absence, the medical officer of the day. Ambulances will not be ordered out by noncommissioned officers on duty in the receiving and disposition office without authority of the receiving and disposition officer or in his absence, the medical officer of the day, unless the emergency is so great that the delay in obtaining such authority is inadvisable. In such cases report is made to the proper officer at the earliest opportunity.

48. Reports.—The receiving and disposition officer is responsible for the preparation and disposition of the following records:

a. The forms prepared on the admission of all patients:

(1) Clinical Record, Brief (W. D., M. D. Form No. 55A), prepared in triplicate and initialed by the admitting officer. The original is sent to the ward with the patient, the duplicate to the registrar, and the triplicate to the information office, thence to the chaplain and director of the Red Cross. The duplicate and triplicate copies may be on blank second sheets of approximately the same size as the form.

(2) Ward roster card, prepared in triplicate and accompanying patient to the ward, two copies to be used for ward rosters and one for use with the clinical record jacket.

(3) Deposit slip, patient's funds and valuables, prepared single copy if no deposit is made; in triplicate if deposit is made. All copies of the form are signed by the patient and the admitting officer. In case deposit is made the triplicate copy is given the patient as his receipt, the original and duplicate to the custodian patient's fund with the deposit. If no deposit is made the deposit slip single copy signed by the patient and admitting officer is delivered to the custodian patient's funds and valuables.

b. The reports prepared daily or as otherwise directed:

(1) Admission and departure sheet. A record of patients who have been admitted; who have departed; who have been transferred, with number of the ward transferred from and transferred to, and a record of patients whose status has been otherwise changed. This report covers the period from midnight of one day to midnight of the following day, and is disposed of in accordance with instructions issued from time to time.

(2) Patient's daily classification report.

(3) Daily report of hospital bed status.

49. Out-patients.—*a.* Reports of examination in cases referred for consultation by medical officers, other than members of the hospital staff, to chiefs of service are made to the receiving officer by informal memorandum upon completion of the examination.

b. From the memorandum received, the receiving officer prepares a report of the case in duplicate for the medical officer concerned for signature of the executive officer.

c. When hospitalization is indicated the duplicate of the report with the informal memorandum received from the examining officer is placed in the suspended file, receiving office. Upon admission of patient, report is forwarded to the sergeant major's office for file in patient's 201 file. If hospitalization is not deemed necessary the duplicate is noted immediately by the receiving officer and forwarded to the sergeant major's office for file.

50. Absence of receiving and disposition officer.—During the hours other than those prescribed for the receiving and disposition officer the medical officer of the day assumes and is responsible for the duties of the receiving and disposition officer.

SECTION V

MEDICAL SUPPLY DEPARTMENT

51. Organization.—The medical supply department is a part of the administrative division of the hospital and is under the immediate supervision of an officer designated by the commanding officer. He is known as the medical supply officer and is directly responsible for the efficient conduct of the department.

52. General duties.—*a.* Procurement, storage, issue, and accountability for all medical supplies, equipment, and all Army blank forms and such local blank forms as may be authorized by the commanding officer.

b. Maintenance and operation of such utilities as may be authorized for the repair and upkeep of Medical Department property.

c. Expenditure of all allotments for the purchase and upkeep of medical supplies.

d. Preparation and maintenance of such memorandum receipts, inventories, property reports, returns, and stock record system as are prescribed by proper authority.

53. Supplies, requisition, and issue.—*a. Requisition.*—(1) *Expendable.*—(*a*) Requisitions for expendable supplies are prepared on the typewriter whenever practicable, using the nomenclature, item number, and unit as listed in the Medical Department Supply Catalog. Requisitions are signed by officers in charge of departments, wards, etc., and forwarded to the medical supply officer on days that may be specified by the commanding officer.

(*b*) In an emergency in which the need could not have been foreseen, requisitions may be submitted at any time. Such requisitions are prepared as directed and marked "Emergency."

(2) *Nonexpendable.*—Requisitions for nonexpendable medical property are made in the manner prescribed in (1) above, except they will be prepared in duplicate on Issue Slip, Nonexpendable Medical Property (W. D., M. D. Form No. 16b). The original copies of the requisition are retained by the medical supply and the duplicate returned to the responsible officer for file as a voucher to memorandum receipt for nonexpendable property.

b. Issue.—(1) The medical supply officer inspects all requisitions and reduces excessive amounts requisitioned to meet the allowances prescribed by The Surgeon General.

(2) Regular issues are made at the medical supply department at specified times. Supplies not called for within the specified hours are returned to stock.

(3) Issues of drugs are made to the pharmacy and dispensed by that department on prescriptions. Exceptions to this rule are made only in the case of articles stored for the use of a specific service.

(4) Articles entering into the composition of surgical dressings are issued in bulk to the surgical dressing room. All dressings are prepared and sterilized in the preparation room pertaining to that section and issued to wards, departments, etc., as required.

54. Alcohol, narcotics, and habit-forming drugs.—*a.* The medical supply officer is directly charged with the safekeeping of all stores of ethyl alcohol, absolute alcohol, alcoholic liquors, narcotics, and habit-forming drugs until they are issued to the pharmacy or other departments authorized to draw such supplies. He receives and issues these supplies in person. All reserve supply of these articles is kept locked in safes in the room especially provided for that purpose in the medical storeroom. All keys and safe combinations are kept at all times by the medical supply officer personally. He keeps a detailed account of his issues on Return of Medical Property Slip (W. D., M. D. Form No. 17a), keeping as vouchers requisition Issue Slip, Expendable Medical Property (W. D., M. D. Form No. 16a) upon which issues were made.

b. Issues of ethyl alcohol, alcoholic liquors, narcotics, and habit-forming drugs are made only to the officer in charge of the pharmacy upon requisition signed by him.

c. Alcohols, alcoholic liquors, narcotics, and habit-forming drugs in the possession of the medical supply officer are checked once each month by an officer designated by the commanding officer. Written report of the findings is made to the commanding officer immediately thereafter.

55. Property.—*a. Responsibility.*—The medical supply officer maintains the account of property on memorandum receipt as prescribed in paragraph 5*a*(1), AR 35–6520. These receipts are prepared in duplicate, renewed semiannually or when property responsibility is transferred. Memorandum receipts presented to responsible officers are checked immediately by them and the original signed and returned to the medical supply officer within 72 hours, the duplicate to be filed in the ward or department. All notations of the responsible officer are made on the duplicate. In no case are original copies changed or notations made by other than the accountable officer. Transfers made for convenience during short leaves of absence or within a short time subsequent to issue of a new memorandum receipt are made by receipt of new officers on reverse of old receipt.

b. Exchange and replacement.—(1) Unserviceable nonexpendable property for exchange is turned in to the medical supply office at specific hours. Property is listed on Exchange Slip, Nonexpendable Medical Property (W. D., M. D. Form No. 16d) in single copy and

is certified by the responsible officer that the article or articles were worn out through fair wear and tear in the public service. W. D., M. D. Form No. 16d is submitted to the medical supply officer. Medical property becoming unserviceable through other than the above conditions is acted on in accordance with paragraphs 1 and 2, AR 35–6640. Similar action is taken when property is lost.

(2) All supplies classed as "expensive" by The Surgeon General which have become unserviceable through fair wear and tear in the public service are accompanied with a certificate in quadruplicate signed by the responsible officer covering the unserviceability. This certificate gives all information required by paragraph 3*b*, Medical Department Supply Catalog.

(3) Duplicate copies of Statement of Expenditure of Special Dental Materials (W. D., M. D. Form No. 18b) are furnished by the chief of dental service covering monthly expenditure of dental gold.

(4) Nonexpendable property no longer required for current use is turned in to the medical supply office. This property is listed on Credit Slip, Nonexpendable Medical Property (W. D., M. D. Form No. 16c), in duplicate, signed by the responsible officer and submitted to the medical supply officer for approval and credit. The medical supply officer signs the duplicate copy of W. D., M. D. Form No. 16c, and returns it to the responsible officer for file with his memorandum receipts.

c. Monthly check.—(1) Officers having property on memorandum receipt check all property for which they are responsible on the first day of each month. Report of such check, prepared in duplicate, listing all overages and shortages found, is made and the original forwarded to the adjutant not later than 12:00 noon the following day, the duplicate to be retained by the responsible officer.

(2) The adjutant forwards these reports to the medical supply officer who consolidates the lists of overages and shortages as prepared by the responsible officer, making such adjustments as are possible, and reports his action to the commanding officer.

(3) Under existing regulations accountable officers are required to take up as "found at post" all property in excess of that listed on their stock record accounts. To avoid duplication of accountability, responsible officers are directed to report all articles in excess of their responsibility in order that adjustments may be made of shortages found in other departments. In the event that adjustments cannot be made of property lost, the responsible officer is directed to proceed as set forth in AR 35–6640.

(4) The medical supply officer or his assistant from time to time checks wards and departments to determine the accuracy of check reported by such ward or department. The officer in charge of ward or department accompanies the medical supply officer while check is being made and renders such assistance as may be required to secure an accurate check. The result of this check is considered final and is reported to the commanding officer by the medical supply officer.

56. Inventories and reports.—*a.* The annual inventory of medical supplies as required by current War Department orders, as well as special inventories and reports of property required from time to time, are prepared and signed by the medical supply officer and forwarded by him through the commanding officer to The Surgeon General of the Army.

b. The medical supply officer prepares and submits to the commanding officer a semiannual statement of cost of medical services, as prescribed by paragraph 4, AR 40–1705, covering 6-month periods ending June 30 and December 31 of each year. This report is submitted the 10th day of July and January of each year covering the periods just preceding, or as soon thereafter as complete information can be furnished.

57. Repair and renovation of Medical Department equipment.—Whenever the responsible officer desires repair or renovation of any articles of Medical Department equipment, including instruments, he causes the article to be turned in to the medical supply officer at the Medical Department storeroom, with a statement of work desired. The medical supply officer, upon receipt of such article, either exchanges it for a serviceable article of the same character or causes the necessary repairs to be made. No article of medical equipment is sent to a repair shop by any person other than the medical supply officer.

58. Purchase of materials in open market.—*a.* Requests for purchases of material required by services are made in memorandum form to the medical supply officer by the chief of service concerned. Except in case of emergency, the medical supply officer obtains the approval of the commanding officer or his representative before purchases are made.

b. Purchases of supplies from Medical Department appropriations are not made by any one other than the medical supply officer. Purchases made other than in the authorized manner or orders given in anticipation of future deliveries are charged to the account of the person or persons giving such orders.

c. Monthly report of expenditures against proper appropriation titles are made by the medical supply officer, signed by him as to their correctness, and submitted to the commanding officer by noon on the 5th day of the month next succeeding, or as soon thereafter as complete report can be furnished. This report is as of the last day of the previous month.

d. Report of the medical and hospital department allotments expended by the medical supply officer are reported quarterly. This report supported by accompanying vouchers is forwarded through the commanding officer by the 5th day of the succeeding month, or as soon thereafter as complete information can be furnished. Similar reports are made at the end of the fiscal year as soon as accompanying vouchers can be secured.

59. Transfer of property.—*a.* When property responsibility in a ward or department is ordered transferred from one officer to another, the responsible officer, accompanied by his successor, personally checks all property on memorandum receipt.

b. Upon receipt of orders for change of station or upon change of duties which require transfer of accountability, the medical supply officer requests the Finance Officer, U. S. Army, Washington, D. C., for an audit of his accountability. In the event that his authorized relief has not reported prior to the departure of the medical supply officer, an officer of the Medical Department is temporarily appointed to assume medical accountability, receipt being taken as required in paragraph 1, AR 35-6680.

c. When the accountable officer is relieved of his accountability by reason of leave, illness, special duty from station, or other authorized temporary absence in which it is not deemed necessary to make complete change of accountability, he makes such certificates as are specified in paragraph 1, AR 35-6680.

60. Requisition by medical supply officer.—*a.* The medical supply officer is charged with the timely requisitioning for such amounts of medical supplies as are needed for the requirements of the hospital. He requests such data from the services as he may deem necessary and chiefs of services give such assistance as he may require in the preparation of these requisitions.

b. Quarterly nonstandard requisitions for nonstandard drugs, instruments, special appliances, and equipment are submitted by the medical supply officer. He calls on the chiefs of services for an estimate of the supplies needed, consolidates these requests, and submits his requisition to the commanding officer. Chiefs of services are directed to reduce their requests for nonstandard articles to the

minimum required by absolute necessity. Requests for proprietary medicines, instruments, and appliances for which a suitable substitute is listed on the medical supply table are prohibited.

SECTION VI

ADMISSION OF PATIENTS

61. Supervision.—The receiving and disposition officer has charge of the admission to hospital and assignment to proper wards of all patients. His duties are assumed by the medical officer of the day when the receiving and disposition officer is absent (see pars. 40 and 41).

62. Personnel entitled to admission.—Personnel entitled to admission to hospital are enumerated in paragraph 6, AR 40-590.

63. Funds, valuables, clothing, and baggage.—Upon admission of patients to hospital, the procedure relative to funds, valuables, clothing, and baggage followed is as prescribed in sections IX and XIII (par. 8*c*(1), AR 40-590).

64. Channels; examination.—*a.* All patients are admitted through the receiving and disposition office where the required admission data are made of record (par. 66), and assignment to proper ward effected. In emergency cases the patient may be taken directly to the ward and necessary admission data obtained later.

b. Patients other than those on the status of officers, emergency cases, and cases (see par. 67) who report to the receiving and disposition office for admission are examined after which they are required to deposit all personal clothing and hand baggage, except the articles specified in paragraph 111, in the patients' baggage room and receive in exchange for such personal clothing the following articles of hospital clothing: One suit of pajamas, one convalescent suit, if available, and one bathrobe. They are then assigned to an appropriate ward without delay.

c. A list is maintained in the receiving and disposition office designating the types of cases normally admitted to each ward to be used as a guide to assist in making the proper ward assignments

and to obviate transfers or adjustment later. Wards accept without question patients assigned thereto by the receiving and disposition officer. Any reassignment that may appear necessary is effected as prescribed by the commanding officer.

d. Patients admitted to hospital are examined physically without delay by the receiving and disposition officer or his representative, and in his absence by the medical officer of the day. Such orders are given as may be necessary relative to the treatment, care, etc., unless arrangements for the patient's admission have been made in advance. After assignment has been made to a ward, the patient is conducted thereto by an attendant from the receiving and disposition office, who in all cases carries the patient's baggage.

65. Arrival by rail or boat.—See paragraph 42*c*.

66. Reports rendered upon admission direct from other stations.—*a. By receiving and disposition officer.*—Whenever an officer, warrant officer, enlisted man, or other militarized person from another post, camp, or station is admitted direct, the fact, date, and time of admission, together with a notation as to status of patient as disclosed by interrogation at time of admission, are entered on the admission sheet. Such records, orders, or other papers which can be furnished by the patient and which serve to explain his status are turned over to the adjutant as soon as practicable.

b. By registrar.—On the morning after admission of cases referred to in *a* above, the registrar dispatches by mail formal notification of the admission to the patient's commanding officer or other proper authority. In cases where it appears that the report should be dispatched by telegraph or radio, the facts are reported to the adjutant for appropriate action.

67. Records.—The receiving and disposition officer is responsible for the preparation and disposition of the records as prescribed in paragraph 48.

68. Procedure on certain types.—*a.* Patients with communicable diseases are not permitted to leave ambulance or enter the receiving and disposition office, but after having been seen by the receiving and disposition officer are sent directly to the isolation ward.

b. When prisoners or insane cases are admitted, their guard or attendants escort them to the proper ward accompanied by an orderly from the receiving and disposition office.

c. Upon the admission of emergency surgical cases where operative procedure is indicated during hours other than those when the operating room is open, the receiving and disposition officer causes the emergency operating room personnel, including nurses and enlisted

men, to be notified immediately in order that the operating room may be made ready to function.

SECTION VII

DISCHARGE OF PATIENTS

69. Recording.—The receiving and disposition officer supervises the recording of the discharge of patients from the hospital.

70. Procedure for other than separation from service or transfer to another hospital.—When it has been determined that a patient is to be discharged from the hospital, the procedure outlined below will be followed:

a. Patients on officer status.—(1) Upon completion of treatment the ward officer closes the clinical record by bringing the progress notes up to date, and initiates a single copy of the disposition slip. The clinical record and disposition slip are sent by the ward officer to the chief of the service concerned.

(2) Upon receipt of the clinical record and the disposition slip, the chief of the service carefully checks the clinical record and makes final decision as to whether the patient should be discharged from hospital. When he is of the opinion that patient requires further hospitalization he returns the papers to the ward officer with a memorandum of instruction. In the event he approves of the discharge, the disposition slip is initialed by him and forwarded to the adjutant. If board proceedings are necessary the disposition slip is retained by the chief of service until such proceedings are accomplished. The board proceedings and the disposition slip are then forwarded to the adjutant. When the disposition slip is forwarded to the adjutant, the clinical record is returned to the ward officer with appropriate notations thereon, and is held by him until the patient's discharge is effected.

(3) Upon receipt of the disposition slip by the adjutant, orders are requested if necessary. When the necessary orders have been received, or immediately in cases where orders are not necessary, the adjutant notifies the ward officer to send the patient to the sergeant

major's office for settlement of his accounts and to acknowledge receipt of his orders. The patient is then discharged from the hospital. Upon discharge from hospital the adjutant forwards the completed disposition slip to the receiving and disposition officer. The ward officer, when notified by the adjutant to send the patient to his office for discharge, closes the clinical record as soon as practicable and sends it to the registrar.

b. Patients on enlisted status.—(1) Upon completion of the treatment the ward officer closes the clinical record and initiates a single copy of the disposition slip. The clinical record and disposition slip are then sent to the chief of the service concerned. Upon receipt of the clinical record and disposition slip the chief of service carefully checks the clinical record and makes final decision as to whether the patient should be discharged from the hospital. When he is of the opinion that the patient requires further hospitalization he returns the papers to the ward officer with a memorandum of instruction. In the event he approves of the discharge, request for orders for enlisted men are prepared for the signature of the adjutant and forwarded to the adjutant's office. The approved disposition slip and clinical record are forwarded to the commanding officer, detachment of patients, by the chief of service.

(2) Prior to the discharge of enlisted patients other than from command, the commanding officer, detachment of patients, furnishes the patient with a clearance form, Notice of Separation from the Service, and instructs him to have it initialed by the heads of the departments concerned and return the form to the detachment of patients office, where it is filed in his 201 file.

(3) Upon receipt of special orders by the commanding officer, detachment of patients, for enlisted men, or immediately upon receipt of disposition slip in other cases, he notifies the ward officer to send the patient to the office of the commanding officer, detachment of patients, who secures the necessary transportation for the patients from the quartermaster; prepares a clearance on Patient's Property Card (W. D., M. D. Form No. 75); instructs the patient to proceed to the baggage room to procure his clothing and return to the office of the commanding officer, detachment of patients. He then on his return receives his transportation and is discharged.

(4) The commanding officer, detachment of patients, retains all disposition slips and clinical records until the patients are discharged. He then causes them to be forwarded by 4:00 PM the same day, the completed disposition slip to the receiving and disposition officer, and the clinical records to the registrar.

71. Separation from service or transfer to another hospital.—*a. Officers.*—(1) When the adjutant receives proper military information that an officer patient is to be separated from the service or transferred to another hospital, he notifies the ward officer concerned. The ward officer closes the clinical record, initiates a disposition slip, and sends them together to the chief of the service concerned. The chief of the service carefully checks the clinical record, and if he approves he so marks the disposition slip and returns it to the ward officer. He also approves the clinical record, has prepared from it an abstract to accompany patient being transferred to other hospital, and then transmits the clinical record to the registrar.

(2) When the adjutant is ready for the discharge or transfer of the officer he has the ward officer send the officer with the disposition slip to the office of the sergeant major where the officer is required to settle his accounts. When the patient is a litter case, accounts may be settled as described in paragraph 26. The disposition slip then is completed by the adjutant who notes on the disposition slip the exact time of departure of the officer. The completed disposition slip is forwarded by the adjutant to the receiving and disposition officer who uses it as his authority to drop the officer from the records of the hospital.

(3) In the case of an officer who is retired from active service or a Reserve officer who is relieved from active duty and remains a patient in the hospital the clinical record and disposition slip are disposed of as in (1) above except that no abstract is made. When the actual time of transfer of status has arrived, the adjutant notifies the ward officer and calls for the disposition slip. He then marks the disposition slip to show the actual disposition of the officer and transmits it to the receiving and disposition office.

b. Enlisted men.—(1) When an approved CDD or a request for orders to transfer an enlisted man to another hospital is received by the commanding officer, detachment of patients, he immediately calls the ward officer conecerned, informs the ward officer of the probable date of discharge or transfer of the patient, and requests that the complete clinical record and disposition slip be forwarded as soon as practicable to the chief of the service concerned. The ward officer then completes the clinical record, initiates the disposition slip, and forwards them together to the chief of service concerned. The chief of the service carefully checks the clinical record. An abstract of the clinical record for cases transferred to other hospitals is prepared

in his office from the clinical record to accompany cases to be transferred. He forwards the approved disposition slip and clinical record to the commanding officer, detachment of patients, where they are held until the discharge or transfer has been completed.

(2) The commanding officer, detachment of patients, proceeds to prepare the necessary final papers for enlisted men and has them ready for delivery to the patient on his discharge or to the hospital to which he is being transferred on the date of transfer.

(3) On the date that the patient is actually discharged or transferred the commanding officer, detachment of patients, completes the disposition slip, stating on it whether the patient is actually leaving this hospital or remaining under the authority of AR 40–590 as a retired enlisted man or as a beneficiary of the Veterans Administration. At the same time he transmits the clinical record to the registrar.

c. Action by receiving and disposition officer.—When the completed disposition slip is received by the receiving and disposition officer from either the commanding officer, detachment of patients, or the adjutant, it is his authority for dropping the patient from the records of the hospital. When the disposition slip shows that patient is remaining in hospital as a retired officer, Reserve officer not on active duty under AR 40–590, as a retired enlisted man, or as a beneficiary of the Veterans Administration, he prepares on the following day a new W. D., M. D. Form No. 55A, giving the patient a new register number, and disposes of this new W. D., M. D. Form No. 55A as in paragraph 48.

72. Leave or furlough.—*a.* When a military patient is authorized to depart on leave or furlough, the ward officer concerned brings the clinical record up to date, prepares a disposition slip, and sends both the clinical record and the disposition slip by an attendant with the patient to the receiving and disposition office. The disposition slip is appropriately marked to show the time patient departs on leave or furlough and the time of his expected return, and is attached to the clinical record. The patient is instructed that on his return he reports first to the receiving and disposition office. The clinical record is retained by the receiving and disposition officer until the return of the patient, at which time it is forwarded to the ward to which the patient may be assigned.

b. If the patient fails to return on time and no extension of his time is authorized by the commanding officer, an appropriate entry is made on the disposition slip to show the patient as AWOL, an entry to the same effect is made on the admission and departure sheet and the case is handled as described for AWOL cases in paragraph 73.

73. Absence without leave.—*a.* Whenever a patient of any status leaves the hospital without leave, the ward officer brings the clinical record to date and makes a single copy of the disposition slip, entering thereon the time and day of the patient's departure. He immediately transmits both the clinical record and the disposition slip to the receiving and disposition officer, who retains the clinical record for military patients 30 days. If the patient has not reported within this time, the receiving and disposition officer drops him from all records of the hospital and transmits the clinical record to the registrar.

b. If the patient returns to the hospital within the time indicated in *a* above he is disposed of as indicated at the time, and the clinical record is sent to the ward to which he is assigned.

74. Hospital to quarters status.—When it is desired to change the status of a military patient from "hospital" to "quarters," the ward officer brings the clinical record to date, makes such entries therein as may be appropriate, and prepares a single copy of the disposition slip so altered as to show plainly that the patient is going on a quarters status, after which he transmits both records to the chief of service. If the chief of service determines that the patient can be treated properly in quarters, he approves the disposition slip and forwards same with clinical record to the sergeant major, who makes the proper record and forwards the papers to the officer in charge of the dispensary. If the patient is an officer responsible for his own subsistence, his subsistence account is settled in the same manner as specified in paragraph 26. At an appointed time the ward officer directs the patient to report to the officer in charge of the dispensary, who gives him the necessary instructions to report each day and any other pertinent professional direction. He sends the disposition slip with appropriate remarks to the receiving and disposition officer and holds the clinical record himself. The receiving and disposition officer takes such information as he needs from the disposition slip and returns it. When the case is completed the officer in charge of the dispensary completes the disposition slip and clinical record and disposes of them as directed in paragraph 70*b*(4).

75. Records; admission and disposition list.—In accordance with the instructions contained herein, a disposition slip is furnished the receiving and disposition officer in all cases where a patient departs from the hospital except in case of death. The receiving and disposition officer takes steps to assure himself that the admission and disposition sheet is promptly and accurately prepared and that

it shows all discharges for the preceding 24 hours. He obtains informally from the registrar and administrative officer of the day the data relating to deceased patients. If the receiving and disposition officer is informed that a patient for whom he has a proper disposition slip has not been discharged, he communicates with the ward officer and makes appropriate adjustment.

76. Clearance.—Except such clearance as may be required by the commanding officer, detachment of patients, and the adjutant in the case of military patients, patients are not required to obtain clearance before departure inasmuch as the receipt for subsistence charges furnished by the director of dietetics to pay patients is prescribed in lieu thereof.

SECTION VIII

SERIOUSLY ILL PATIENTS

77. Report by ward officer.—In every case when recovery from illness or operation is not expected or is considered doubtful, the ward officer in charge of the case enters the patient's name on the list of seriously ill as prescribed in paragraph 80 below, and then prepares and signs a Report of a Seriously Ill Case. Particular attention is given to the name, relationship, and address of the person to be notified in case of emergency. This information is transmitted immediately to the administrative officer of the day for the action indicated in paragraph 78. As soon as possible after a patient's name is placed on the seriously ill list, the ward officer makes an attempt to induce him to turn over his money and valuables for safekeeping to his relatives if they are present, or to the registrar. Tact will be used in handling this matter so as not unduly to alarm the patient. In the event that the patient declines to turn over his money and valuables to relatives or to the registrar, the ward officer makes it clear to him and to his relatives that the hospital will not assume responsibility for any loss sustained. If the patient is semicomatose or unconscious, the ward officer collects money and valuables in possession of the patient and turns them in to the registrar for safekeeping. In the absence of the ward officer, the above procedure is

carried out by the professional officer of the day or any other medical officer who may be called in attendance.

78. **Information office action.**—*a. Noncommissioned officer in charge.*—(1) Upon receipt of a report of a seriously ill case during office hours, it is noted promptly and initialed by the noncommissioned officer in charge of the information office, with notation of time received, after which action he immediately delivers it to the registrar for further appropriate action, and advises the indicated chaplain of the patient's condition. He keeps posted in a conspicuous place in the information office a list showing the name, status, and ward of all patients in whose cases such reports have been received.

(2) Upon receipt of a report of a seriously ill case during other than office hours, the noncommissioned officer in charge of the information office proceeds as directed in (1) above except that the report is delivered immediately to the administrative officer of the day.

b. Administrative officer of day.—Upon receipt of a report of a seriously ill case, the administrative officer of the day promptly notes and initials the report and, if immediate action is indicated, he personally verifies the name and address of the person to be notified with that shown in the information office index card and notifies the designated relative or friend by telegram of the patient's condition. The report of seriously ill case, together with a copy of telegram sent, is transmitted to the registrar by the administrative officer of the day.

79. **Registrar's action.**—Upon receipt of a report of a seriously ill case, the registrar immediately places the patient's name on the list of seriously ill cases maintained in his office, notifies the information office, and sees that the patient's name is placed on the list of seriously ill maintained in that office. He then takes such action toward notifying the relatives or friends as may be indicated, after which the form, accompanied by a copy of the telegram or letter of notification, is retained in a live file until final disposition of the case has been made. In the event of patient's death the form is appended to the death records of the case.

80. **Cessation of condition.**—When a patient who has been reported seriously ill (par. 77) is considered out of danger, the ward officer in charge of the case removes his name from the list of seriously ill maintained in the ward office and then prepares and signs a Report of Removal from Seriously Ill List and forwards the report to the registrar. Upon receipt of the form, the registrar immediately removes the name of the patient from the seriously ill list maintained in his office and notifies the relative or friend previously ad-

vised of the patient's condition. He also informs the noncommissioned officer in charge of the information office, who removes the patient's name from the list of seriously ill.

81. List.—*a.* A list of seriously ill is maintained in—

(1) Information office.

(2) Registrar's office.

(3) Each ward office.

b. The lists maintained in the information office and registrar's office carry the names of all patients who have been reported seriously ill until such a time as report of removal from seriously ill list is received.

c. Ward officers keep a list of all patients in their wards who have been reported seriously ill in conformity with *a* above. This list is prepared and is conspicuously displayed at all times on the nurse's desk, and checked daily by the ward officer to see that it is kept up to date and that the names of those patients who are no longer seriously ill have been removed from the list and that they have been reported as prescribed in paragraph 80. If there are no seriously sick in a ward, remark to that effect is entered on the form.

82. Transfer to another ward.—When a patient carried on the seriously ill list is transferred to another ward, the transferring officer removes his name from the list maintained in his ward and makes the following notation in a conspicuous place on the face of the request for transfer of patient which accompanies the patient: "Patient on seriously ill list." The ward officer of the ward to which the patient is transferred places the patient's name on the seriously ill list of that ward as soon as possible after the transfer is completed.

SECTION IX

PATIENTS' FUNDS AND VALUABLES

83. Custodian.—The registrar is the custodian of patients' funds and valuables, and is personally responsible for safeguarding them after they have been delivered to him. Patients' funds are deposited

in a local bank and disbursed in the form of checks by the custodian personally.

84. **Audit.**—*a.* At the end of each month the hospital inspector audits the patients' funds and valuables. The duties of the auditing officer are to—

(1) Audit the fund account, examine into sources from which the fund has accrued, and into all disbursements so as to assure himself that all funds deposited have been properly acounted for and that disbursements have been properly made.

(2) Verify the balance of the fund shown as remaining on hand.

(3) Verify the deposit of and return of valuables to patients.

(4) Verify the list of valuables noted as remaining on hand.

b. Upon the completion of the audit, the auditing officer places a certificate above his signature in the cash book kept by the custodian of patients' funds and valuables certifying that he has audited the fund and verified the funds and valuables on hand, and that he has found them to be correct; or he notes any irregularity found and reports it to the commanding officer.

85. **Information furnished on admission.**—Upon admission to hospital all patients whose physical and mental condition is such that they can understand are asked by the receiving and disposition officer, or in his absence the medical officer of the day, as to whether they have any funds and valuables in their possesion which they desire to deposit with the custodian of patients' funds and valuables for safekeeping. They should be urged to safeguard their funds and valuables in this manner, and will be distinctly informed that the hospital authorities will not be responsible for loss of either funds or valuables not so deposited.

86. **Deposit certificate.**—In accomplishment of deposit certificates by patient and admitting officer the following procedure is followed:

a. For patient desiring to make deposits.—Patients desiring to make deposits sign a deposit form in triplicate, acknowledging that they have been informed relative to making deposits and itemizing separately thereon the funds and valuables they wish to deposit. The admitting officer signs all copies of the receipt for the articles deposited and delivers the duplicate copy to the patient. The original and triplicate copies, accompanied by the money and valuables listed thereon, are transmitted by the admitting officer personally to the custodian of patients' funds and valuables as soon as practicable. The custodian acknowledges receipt by signature on each copy, returning the triplicate copy to the officer originally receiving the deposit, and files the original copy for future reference.

b. For patients having no money or valuables in their possession.—Patients having no money or valuables in their possession are nevertheless required to sign the deposit form, acknowledging that they have been informed relative to making deposits. The word "None" is noted under the appropriate heading on the form. In such cases only one copy of the form is prepared and signed by the admitting officer, and it is submitted to the custodian of patients' funds and valuables by the admitting officer not later than 9:00 AM the following day.

c. For mentally or physically incapable.—When patients are admitted who appear to be incapable, mentally or physically, of following the procedure outlined in *a* and *b* above, the following procedure is followed:

(1) A careful and thorough search of patient's person and effects is made by the admitting officer personally, who takes therefrom any money or valuables which he may find. This search ordinarily is conducted in the presence of a witness whose signature is obtained on the form.

(2) Attendants accompanying mentally or physically incapable patients for admission are asked whether or not money and valuables belonging to patient are in their possession. Any articles delivered by attendants, together with those found on patient's person, are itemized on local deposit form in quadruplicate, which is signed by the attendant when there is one, and receipted by the admitting officer. The form is suitably altered for the purpose indicated and a notation is made thereon as to the reason for the patient not executing the form. In addition, notation is made of the name and status of attendant. The duplicate copy is furnished the attendant. The original, triplicate, and quadruplicate copies, together with the money and valuables, are taken by the officer accomplishing the form as soon as practicable to the custodian of patients' funds and valuables, who receipts and returns the quadruplicate copy to the officer originally receiving the deposit, delivers the triplicate copy to the ward to which the patient is assigned, and files the original for future reference. When no funds and valuables are delivered by attendants or found on patient's person, but one copy of the form is accomplished by the admitting officer, in which case the word "None" is noted under the appropriate heading on the form, and the form signed by the attendant and the admitting officer. It is sent to the custodian of patients' funds and valuables not later than 9:00 AM the following day.

(3) When patients are unaccompanied by attendants, the procedure is the same as prescribed in (1) and (2) above, except that when

money and valuables are found on the patient's person, the admitting officer accomplishes the form in triplicate only, all copies being taken to the custodian of patients' funds and valuables who signs all copies, returns the triplicate to the officer originally receiving the deposit, delivers the duplicate to the ward to which patient is assigned, and files the original for future reference.

(4) In the event of the transfer of a patient from an open to a closed ward, the ward officer of the ward from which the patient is transferred, or in the absence of the proper ward officer, the officer of the day of the service responsible for the care of the patient, makes a search of the patient's person, clothing, bed, bedside table, and of the ward for money and valuables belonging to the patient. Any money or valuables found are itemized in triplicate and signed by the officer making the search. This search ordinarily is made in the presence of a witness who also signs the forms. After this action the forms, together with any money or valuables found, are delivered in person by the officer to the custodian of patients' funds and valuables, who signs all copies, returns the triplicate to the officer making the search, delivers the duplicate to the ward to which the patient is transferred, and files the original for future reference.

(5) In the event of the transfer of a patient to the guard house or detention ward, the prison officer, or in his absence, the administrative officer of the day, carries out the provisions of (4) above, except that the duplicate copy is given to the patient by the officer making it.

(6) Prior to an operation involving the use of a general anesthetic or in any circumstances where the patient is rendered unable or incompetent to care for such money and valuables as he may have in his possession, the ward officer of the ward to which the patient is assigned, or in his absence the officer of the day of the service responsible for the care of the patient, takes from the patient all such money and valuables. Such money and valuables taken from the patient are itemized on the deposit form in triplicate and all copies of the form signed by the patient and by the officer making it, the duplicate to be given to the patient. After this action the forms, together with any money or valuables found, are disposed of as described above.

(7) Whenever a patient is reported as seriously ill or is incompetent for any reason to care for his money and valuables, the ward officer of the ward to which the patient is assigned makes an immediate search of the patient's person, bed, bedside table, clothing, and of the ward for any money and valuables belonging to the patient and then proceeds as described above.

87. Subsequent deposits while in hospital.—*a.* Patients who desire to deposit money or valuables during their stay in the hospital, if their physical condition permits, makes such deposit personally with the custodian of patients' funds and valuables. If deposit was made on the patient's admission he brings with him the deposit form which he holds as a receipt and any supplementary deposit is entered in the appropriate place on that form and signed by the custodian of patients' funds and valuables. If the patient has not previously made deposit he accomplishes with the custodian of patients' funds and valuables a deposit form in duplicate, receiving from the custodian the signed duplicate form as his receipt.

b. Patients whose physical condition prevents them from making deposit in person make it through their ward officers. If the patient has not previously deposited with the ward officer he makes a local deposit form in triplicate as directed in paragraph 86*a*. If he has previously deposited he delivers to the ward officer the funds and valuables he desires to deposit, together with his retained deposit form. In each case the ward officer delivers in person to the custodian, patients' funds and valuables, the original and duplicate deposit form which he made with the patient or the deposit form which he received from the patient, together with the funds and valuables. The custodian in the first case signs the triplicate and returns it to the ward officer. In the second case, he enters the supplementary deposit in the appropriate place on the form and initials it.

88. Withdrawal.—*a.* Patients desiring to withdraw their personal funds and valuables do so in person if their physical and mental condition permits, delivering their deposit form to custodian and signing for funds and valuables withdrawn. The ward officer of the ward to which the patient has been assigned is required to identify the patient by placing his signature in the appropriate place on the form unless the patient is personally known to the custodian of patients' funds and valuables.

b. Patients desiring to withdraw funds or valuables who are not physically able to come personally to the office of the custodian of patients' funds and valuables deliver the deposit receipt to their ward officers in person. The ward officer in turn represents the patient in the office of the custodian of patients' funds and valuables, makes the requested withdrawal, and signs for it.

89. Deceased patients.—Upon the death of a patient the ward officer, or in his absence the officer of the day of the service responsible for the case, makes an immediate search of the deceased person, his bed, bedside table, and of the ward for clothing, money, valuables, or

other effects belonging to the patient. Any money or valuables found are itemized on a deposit form in duplicate, and the form signed by the officer making the search. This search ordinarily is made in the presence of a witness who also signs the form. After this action the forms, together with any money and valuables found, are delivered *immediately* in person by the officer making them to the custodian of patients' funds and valuables, who signs both copies, delivers the duplicate to the officer who presented them, and files the original for future reference. *If death occurs during closed office hours, the officer will deliver them at 9 AM the following day.*

90. Financial transactions with patients.—No enlisted man or civilian employee of the command will have any financial transactions whatsoever with patients. Under no circumstances will money or valuables of patients be received or delivered by them.

SECTION X

DISEASE OR INJURY

91. General provisions.—AR 35-1440 prohibits pay, as distinguished from allowances, to any person in the military or naval service for the period of absence from duty in excess of 24 hours if the absence is due to disease as distinguished from injury resulting from his own intemperate use of drugs or alcoholic liquors, or from veneral disease acquired through misconduct, provided the absence from duty due to veneral disease is within 1 year following the appearance of the initial symptoms and regardless of whether the initial symptoms appeared prior to or subsequent to enlistment, except that each person whose pay is forfeited for a period in excess of 1 month at any one time is paid for necessary personal expenses $5 for each full month during which his pay is forfeited.

92. Two or more disabilities.—When a patient is hospitalized for two or more disabilities one of which comes within the purview of AR 35-1440, the major disability determines his pay status. In such cases if the need for hospitalization for the major disability ceases and the patient remains in hospital for treatment of the lesser condition, the date of cessation of treatment for the major condition is the

date of the change in the pay status of the patient, and is so reported by the ward officer. Veneral diseases contracted while a patient is in hospital does not place the patient on a nonpay status until such time as the original cause of his admission to hospital has reached the stage where hospitalization is no longer required for the cause of admission, when the patient goes on a nonpay status for the further hospitalization required for the disease placing him on the nonpay status.

93. Military patient placed on nonpay status.—*a. Procedure.*—When it has been determined that a military patient is hospitalized for a disease within the purview of AR 35–1440, the ward officer immediately notifies the patient. The patient is informed that if he objects to being placed on a nonpay status he may present his objections in writing and furnish therewith any evidence or facts which he may desire to have considered. In the event objections are presented they are forwarded, together with all medical papers in the case, through the chief of the service to the commanding officer for final decision. If objections are presented and forwarded as prescribed the patient nevertheless is placed on a nonpay status and reported to the commanding officer, detachment of patients, in the same manner as indicated in *b* below pending final decision in the case. Patients placed on a nonpay status acknowledge notification of such fact in a signed statement on the progress sheet of the clinical record in the following form:

> "I have been notified that under the provisions of AR 35–1440, I have been placed on a nonpay status.
>
> (Signed) John Doe (R–5,217,413)
> Pvt., Co. C., 20th Inf."

b. Reports.—(1) *By ward officers.*—When a military patient is placed on a nonpay status, the ward officer immediately furnishes the commanding officer, detachment of patients, a signed report of the diagnosis, a statement that the disease is not in line of duty, AR 35–1440 applies, and the date stoppage of pay became effective. The ward officer also makes report to the commanding officer, detachment of patients, if the nonpay status of a military patient terminates, with the date, and whether or not the patient requires further hospitalization for a condition not involving pay stoppage.

(2) *By commanding officer, detachment of patients.*—(*a*) Upon the receipt of either of the reports referred to in (1) above pertaining to military patients other than enlisted men, and when the patient is returned to duty, the commanding officer, detachment of

patients, prepares a letter for the signature of the adjutant to The Adjutant General setting forth the appropriate data.

(*b*) Upon receipt of either of the reports referred to in (1) above in the case of an enlisted man and when the patient is returned to duty, the commanding officer, detachment of patients, causes the necessary entries to be made on the records of the enlisted man concerned. In the event the records of the enlisted man concerned are not in the custody of the commanding officer, detachment of patients, or in the case of an enlisted man belonging to one of the duty detachments, the commanding officer, detachment of patients, notifies the proper commanding officer.

94. Procedure upon disagreement.—If the ward officer has reason to doubt the justice of the findings determined at the station from which a patient is transferred in a case where a patient has been received by formal transfer, he forwards a report of his findings and recommendations to the commanding officer, detachment of patients. Upon receipt of the findings of the ward officer the commanding officer, detachment of patients, requests a board of officers as prescribed in paragraph 3*b*, AR 345-415. The findings of the board when approved by the commanding officer are final in the case.

95. Absence from duty on account of injury due to own misconduct.—Article of War 107 directs that an enlisted man absent from duty because of injury the result of his own misconduct be continued in the service after his return to a duty status and after his enlistment would normally have expired for such period as will with the time he had served prior to his disability amount to the full term of his enlistment. When a ward officer has determined that an enlisted man in his ward is suffering from an injury as distinguished from disease which was incurred through the patient's own misconduct he proceeds as directed in paragraph 96.

96. Line of duty boards.—*a.* AR 345-415 (par. 1*c*(4)(*b*)) directs that in every case of injury, except battle casualty, which in the opinion of the surgeon is likely to result in a partial or complete disability and eventually be made the basis of a claim against the Government, the commanding officer upon recommendation of the surgeon will convene a board of officers to investigate and report upon the circumstances attending the injury.

b. When a ward officer believes a case in his ward comes within the purview of *a* above, he reports the facts with his recommendation through the chief of the service to the commanding officer, detachment of patients. Upon receipt of the report of the ward

officer by the commanding officer, detachment of patients, he requests the commanding officer to convene a board of officers if the case in question was admitted from command. If the case was admitted from another command either by formal or informal transfer the commanding officer, detachment of patients, unless he has reason to believe a board of officers has been convened prepares a letter for the signature of the adjutant to the enlisted man's commanding officer requesting a board of officers be convened. The letter requesting a board will state the nature and location of the injuries for which the enlisted man is hospitalized.

c. Upon receipt of the approved proceedings of a board of officers the commanding officer, detachment of patients, causes the necessary entries to be made on the records of the enlisted man and furnishes the ward officer with a copy of the findings of the board. The ward officer makes the necessary entries on the clinical record. Upon completion of treatment the ward officer immediately notifies the commanding officer, detachment of patients, of the fact and date of completion of treatment. Upon receipt of that report by the commanding officer, detachment of patients, he causes the necessary entries to be made on the records of the enlisted man.

SECTION XI

ACTION ON DISCHARGE FOR DISABILITY

97. Ward officer.—When a ward officer is of the opinion that a case in his ward has a disability which permanently unfits him for further military service he obtains from the registrar all clinicial records of the enlisted man's previous admissions to the hospital, and a statement from the commanding officer, detachment of patients, showing the date the enlistment will expire. When the case has reached maximum improvement or 30 days preceding the date of the ETS, the ward officer furnishes the registrar through the chief of service data for preparing certificate of disability for discharge. All clinical records in the case are forwarded to the chief of service. The chief of service, if he approves the action of the ward officer, initials and forwards to the registrar.

98. Registrar.—*a. Action.*—The registrar, upon receipt of clinical records, obtains any further information relative to cause of dis-

ability and line of duty that may appear necessary. Such additional evidence when obtained is filed with and becomes a part of the medical records of the case. The registrar notifies the ward officer of the ward in which the patient is located of the time, date, and place of the meeting of the disability board, and issues instructions for the patient to appear before the Board. The commanding officer, detachment of patients, prepares and signs the first page of Certificate of Disability for Discharge (W. D., A. G. O. Form No. 40). The second page of W. D., A. G. O. Form No. 40 is completed by the registrar and signed by the members of the disability board. The forwarding indorsement is prepared by the registrar for the signature of the adjutant. After action by the disability board the clinical records are returned to the ward concerned.

b. Supervision of clerical work.—The registrar coordinates all matters relating to the discharge of enlisted patients on certificates of disability. He is responsible that the entries on the certificate of disability are correct and that upon completion of the discharge the certificate of disability and allied papers are disposed of as directed by section 11, AR 615-360.

99. Approved certificate of disability.—Upon the receipt of an approved certificate of disability for discharge the commanding officer, detachment of patients, effects the discharge of the patient and takes the necessary action to comply with paragraph 16, AR 615-360.

100. Enlisted members of permanent command.—When the discharge for disability of an enlisted member of the permanent command is contemplated his detachment commander indorses the enlisted man's service record as prescribed by existing regulations to the commanding officer, detachment of patients, and at the same time transfers all personal effects which have been in store in his custody to the patient's baggage room and obtains a receipt therefor. The commanding officer, detachment of patients, disposes of the case in the same manner as other cases in hospital.

SECTION XII

DEATHS

101. Administrative and clerical jurisdiction.—The registrar exercises administrative and clerical jurisdiction over all details in connection with deaths which occur in the hospital. This duty includes the preparation and rendition of the necessary certificates, routine reports, and records incident thereto. In the performance of the aforementioned duties, the registrar is governed by the provisions of existing Army Regulations and such other pertinent official orders and instructions as may be issued.

102. Notification.—In case of approaching death of a patient, the nurse in charge notifies the noncommissioned officer in charge of the information office who notifies the indicated chaplain.

103. Procedure.—If death of a patient occurs, the body is not removed from the ward until death has been pronounced by a medical officer. Before removal of remains from the ward, three death tags properly prepared and signed by the medical officer in attendance at time of death are securely tied, one to the right toe and one to the right wrist of the cadaver. Before the body is removed from the ward, it is thoroughly washed, eyes and mouth properly closed, all openings properly plugged to prevent discharge, and wrapped in clean sheets so as to prevent exposure of any part of the body. The third death tag is securely attached to the outside of the sheets. Upon completion of the above, the remains are removed without delay from the ward to the morgue with as little disturbance as possible. Transportation of the body to the morgue is as directed by the medical officer in attendance.

104. Death report.—Immediately upon death of a patient the medical officer in attendance is responsible for the death report. If the death occurs during hours in which the registrar's office is closed, the administrative officer of the day is notified. Particular care is exercised that the name and address of the nearest relative, as shown on W. D., M. D. Form No. 55A, is given as the person to be notified.

105. Action by registrar.—Upon receipt of a death report, the registrar takes such immediate action toward notifying or interviewing relatives or friends of the deceased, notifying the undertaker, arranging for post mortem examination, arranging for burial or disposition of remains, advising the chief of the laboratory service of the death, and such other appropriate action as may be indicated for each individual case. As soon as the registrar has obtained the data immediately necessary, they are transmitted to the appropriate chief of service who verifies the cause of death and the contributory cause, returning all data to the registrar who prepares the death certificate

and accomplishes all other details incident to completion of the case, after which a report is filed with the medical records of the case.

106. Responsibility of chief of laboratory service.—The chief of the laboratory service is responsible for the protection and proper care of bodies of deceased persons from the time a body is received in the morgue until it is disposed of in accordance with existing instructions. In all cases where remains are prepared at Government expense he assures himself that the remains are prepared in accordance with sanitary regulations and is responsible for the preparation of the remains for burial or shipment, including verification of the employment by the undertaker of effective and scientific embalming processes, including vessel injection and ligation after autopsy, and sees that the body is properly and completely clothed and ready to be placed in the casket. He makes a final inspection immediately before disposition of a body and verifies the identity of the deceased and the disposition thereof. He submits a signed report in each individual case to the effect that he has inspected the remains, that the remains have been properly prepared and clothed, and that he has verified the identity of the deceased at time of disposition. This report is transmitted to the registrar and filed with the medical record of the case. The removal of remains from the hospital will not be authorized by other than the registrar unless under exceptional circumstances or when relatives of the deceased, after having been informed of this regulation, demand the removal. Under no circumstances, however, will a certificate of death be signed by other than the registrar, the chief, or the assistant chief of the medical or surgical service.

107. Effects of deceased.—Upon the death of a patient, the ward officer, or in his absence the officer of the day of the service responsible for the care of the patient, makes an immediate search of the deceased's person, bed, bedside table, and of the ward for clothing, money, valuables, or other effects belonging to the patient. (See par. 89.) Clothing and effects other than money and valuables that are found are listed on Patients' Property Card (W. D., M. D. Form No. 75), in duplicate, which is signed by the officer making the search, after which the forms, together with such clothing and effects found, are delivered to the patients' baggage room. The registrar is charged with the proper disposal of the clothing, money, valuables, and effects of deceased patients, and in his capacity as summary court officer carries out the provisions of the Manual for Courts-Martial as may be indicated in the case of persons subject to military law, and in all other cases as may be appropriate and in accordance with the existing law. Money and valuables of de-

ceased patients are released by the custodian of patients' funds and valuables, and clothing, effects, and baggage of deceased patients are released from the patients' baggage room only on the written order of the registrar.

SECTION XIII

CLOTHING AND BAGGAGE OF PATIENTS

108. Baggage room.—The patients' baggage room functions under the immediate jurisdiction of the commanding officer, detachment of patients, who is responsible for the safeguarding, proper storage, disposition, and necessary records of all effects which are delivered thereto. In hospitals where there is no baggage room the ward officer is charged with these responsibilities.

109. Disposition of clothing and effects on admission.—*a.* Except when enlisted status patients are admitted directly to the wards, all clothing and hand baggage in their possession are immediately delivered by them with the assistance of personnel from the receiving office to the patients' baggage room. All such clothing and equipment of patients, including the articles comprising hand baggage except as provided in paragraph 111, are inventoried by the attendant on duty in the baggage room, who carefully lists articles on W. D., M. D. Form No. 75, in duplicate. Specific description is noted in the case of unusual items to permit ready identification in the future. The patient is required to sign both copies of the inventory, acknowledging its correctness. If he is unable to do so, appropriate notation is made thereon by the person making the inventory. The attendant on duty in the patients' baggage room stamps with the "Received" stamp and signs each copy of the inventory. The duplicate is delivered to the patient and the original is held on file in the patients' baggage room.

b. (1) When patients are admitted direct to wards or in those cases where the emergency is such that it is not practicable to have the personal clothing and handbaggage turned in at the patients' baggage room, all clothing and handbaggage in their possession are

delivered with the patient to the proper ward by the personnel of the receiving office. In such instances all clothing and equipment of patients, including the articles comprising handbaggage, except as provided in paragraph 110 below, are inventoried by the wardmaster, who carefully lists same on W. D., M. D. Form No. 75, in duplicate. Specific description is noted in the cases of unusual items to permit ready identification in future. If the condition of the patient does not preclude, he is required to sign both copies of the inventory, acknowledging its correctness. If he is unable to do so, appropriate notation is made thereon by the person making the inventory Except in cases of patients admitted to the communicable disease section (see (2) below), both copies of W. D., M. D. Form No. 75, together with the effects, are sent immediately to the patients' baggage room if it is during the hours when the patients' baggage room is open, and if the patients' baggage room is not open as soon after its next opening as possible. *In the latter case, the wardmaster who inventories the clothing and equipment turns it over to the ward nurse and she is responsible for its retention under lock and key in the linen room or other locked depository of the ward until the baggage room is again open.* Under no circumstances will clothing be kept in ward linen closets except for the very temporary period when it is not practicable to have the patients' baggage room open (see *a* above).

(2) Clothing received in the communicable disease section is handled as in (1) above, except that after it has been properly inventoried, such articles as the ward officer designates are delivered to the hospital laundry for disinfection. A receipt from the laundry is taken for all items so delivered. The ward attendant calls at the laundry at the designated time to receive these items after they have been disinfected. He then checks the items against the receipt he received. If found correct he takes the disinfected items received from the laundry, together with all other effects of the patient which have been otherwise disinfected, to the baggage room where he disposes of them as described in *a* above.

110. Wear of hospital clothing.—*a.* When an enlisted status patient has delivered his clothing and personal effects to the patients' baggage room, he is furnished one suit of hospital pajamas and bathrobe, and a receipt is taken by the attendant at the patients' baggage room. He may be permitted to retain his shoes, underclothing, two pairs of socks, waist belt, and the necessary toilet articles. These personal items are not included in the inventory (see par. 111).

b. Patients on an enlisted status admitted direct to wards, if their mental and physical conditions permit, are required to sign a receipt for a suit of hospital pajamas when the same is issued to them on the ward. If they are not able to sign such a receipt, a notation to that effect is made. When clothing and effects are delivered to the patients' baggage room, this receipt is delivered with the clothing to the patients' baggage room and the attendant who delivers them receives from the attendant in return one suit of hospital pajamas. This is delivered to the ward to replace those issued to the patient.

c. Patients on an enlisted status are prohibited from wearing other than hospital clothing while in any building pertaining to the hospital, except that convalescent patients, other than those confined in the neuropsychiatric section, may wear such personal underclothes, shoes, socks, waist belts, and head covering as they have in their possession.

d. Ambulant patients on an enlisted status while in the ward are clothed habitually in pajamas, socks, slippers or shoes, or if available, in a convalescent suit which must be clean and in good state of repair and buttoned at all times.

e. When an ambulant patient on an enlisted status leaves his ward, the Medical Department convalescent suit, if available, is worn over the pajamas. Patients requiring the protection of additional clothing are permitted to wear the bathrobe over the convalescent suit. Except as noted below, this is the patient's dress at all times on the grounds and in the building to which he has access, except going from and returning to the reservation on authorized pass.

f. Patients wear their personal outer clothing when leaving and returning to the reservation on authorized pass.

111. Retention of clothing and property.—Except as noted hereafter, no articles of personal clothing or property are retained in the wards by patients on an enlisted status during stay in hospital. Patients are required to turn in to the patients' baggage room any such articles found in their possession by any of the ward personnel on duty in the ward. Patients whose physical and mental conditions permit them to leave the ward may be granted permission by the ward officer to retain the following articles:

1 pair of shoes.
1 hat or cap.
2 pairs of socks.
2 suits of underclothing.
1 waist belt.
Necessary toilet articles.

Patients are informed when such permission is granted that these articles are for their personal comfort and that they are responsible for any subsequent loss.

112. Baggage when admitted from train or boat.—*a.* Patients admitted from trains or boats are asked at the receiving office whether or not they have any baggage other than that which accompanied them at the time of admission. If so, they are requested to deliver the baggage checks therefor to the receiving office where a record showing the check number, full name, grade, and organization of patient is made in a book kept for that purpose. These checks are promptly delivered to the attendant at the patients' baggage room who receipts in the book for them. He likewise keeps in the patients' baggage room a book where he records the check numbers, full name, grade, and organization of the patient, and delivers these checks to the quartermaster baggage driver on his next trip, having him receipt for them in the book at the patients' baggage room.

b. (1) When such baggage is received from the quartermaster the patient, if he is ambulant, is required to come to the patients' baggage room where he inspects such baggage and assists in the inventory of any baggage which is not sealed by his own lock and key. He and the attendant together see that all additional items are added to both copies of the W. D., M. D. Form No. 75, and acknowledge these additions by their initials opposite the items listed on each copy.

(2) If the patient is not physically or mentally able to do so, an attendant from the ward in which he is confined is required to come to the patients' baggage room where he sees the locked containers and assists with the inventory of effects not locked, and sees that all items are added to W. D., M. D. Form No. 75. Both the attendant from the ward and the attendant at the baggage room acknowledge receipt of these additional items by their initials opposite the items on each copy of W. D., M. D. Form No. 75.

113. Withdrawal from baggage room.—*a.* Clothing of patients departing on pass or furlough may be withdrawn by the patients on presentation of approved pass or furlough. When such withdrawals are made, if they take with them all items listed on W. D., M. D. Form No. 75, the duplicate copy of the form receipted and signed by the patient is returned to the patients' baggage room. If they make a partial withdrawal, taking with them only such items as they need for wearing apparel while on pass or furlough, a receipt is given to the attendant at the patients' baggage room for articles withdrawn. Upon the return of patients from such absence, if their return is between 8:00 AM and 12:00 midnight, they return their clothing imme-

diately to the patients' baggage room. If their return is between 12:00 midnight and 8:00 AM, they take their clothing with them to their wards but return it to the patients' baggage room immediately after 8:00 AM of the same day. In either case the attendant on duty in the patients' baggage room again takes charge of the clothing which was withdrawn and returns to the patient the receipt which he gave for it.

b. Patients are required when discharged from the hospital to take with them all of their clothing and personal effects. When they are ready to depart they present to the attendant at the patients' baggage room the duplicate copy of W. D., M. D. Form No. 75 receipted by themselves, together with a written notification from the office of the commanding officer, detachment of patients, stating that they are prepared to leave the hospital.

c. All patients going on pass or furlough or being discharged from the hospital are required to deliver at the patients' baggage room one suit of hospital pajamas and one bathrobe for which they receive their receipt.

d. Upon the death of a patient, all money and valuables are secured by the ward officer and turned over immediately to the custodian of patients' fund (see pars. 89 and 107).

e. Clothing of patients may be withdrawn for purposes other than indicated in *a*, *b*, *c*, and *d* above only on presentation of a request approved by the ward officer and the commanding officer, detachment of patients. When clothing is withdrawn by patients for the purpose of cleaning, the ward officer sees that the clothing is returned promptly to the baggage room as soon as the cleaning is completed.

114. Officers.—*a.* While patients on officer status are not required to deposit their clothing in the patients' baggage room, the facilities of the baggage room are available to them for safekeeping of trunks and handbaggage, and they may deposit clothing and other effects not classed as valuables in the same manner described above.

b. In addition, patients on officer status arriving by train or boat are asked if they have additional baggage. When they are found to have such baggage it is handled in the manner directed above.

c. Patients on officer status having clothing and effects stored in the patients' baggage room withdraw them as prescribed above.

115. Check of baggage room records.—The admission and disposition sheet furnished for patients' baggage room is checked daily by the attendant in charge thereof to ascertain if any patient has departed, leaving his baggage behind. When baggage of this nature

is found, report is furnished immediately the commanding officer, detachment of patients, for appropriate action.

SECTION XIV

MEDICAL DETACHMENT

116. Jurisdiction.—All members of the medical detachment on duty at the hospital function under the immediate supervision of the commanding officer, medical detachment.

117. Organization.—The organization of the medical detachment is composed of two services, administrative and professional. The routine assignments for these two services are made in the office of the detachment commander.

a. Administrative service.—The administrative service consists of all enlisted personnel, Medical Department, on duty in the several offices and departments of the hospital, whose duties are strictly nonprofessional. This service functions directly under the charge of the first sergeant, medical detachment, who receives his instructions from the commanding officer, medical detachment.

b. Professional service.—(1) The professional service consists of all enlisted personnel, Medical Department, on duty in the professional service of the hospital, including ward attendants, men on duty in the clinics, laboratories, etc. This service functions directly under the charge of a competent noncommissioned officer who is furnished the necessary assistants to permit supervision over the service during the 24-hour period. The hours of duty for each noncommissioned officer are regulated and prescribed by the commanding officer, medical detachment, under whom the service functions. The professional service cooperates with the ward officers and nurses to the end that most efficient enlisted men are supplied for the professional duties devolving upon this class of personnel.

(2) The duties of the noncommissioned officer in charge of the professional service are—

(*a*) To make all emergency details and assignments, and exercise supervision over all enlisted men, Medical Department professional

service, under the jurisdiction of the commanding officer, medical detachment. He makes frequent checks of such personnel to assure himself that all men detailed are actually on duty, performing their respective work satisfactorily, and that they are neat, clean, and in proper uniform at all times. He also checks on the personnel and makes a report to the detachment commander as to their work and their military conduct.

(*b*) The noncommissioned officers in charge during the night tour of duty make such complete rounds of the wards during the night as they deem necessary and as may be prescribed from time to time.

118. Wardmasters.—*a.* In wards where members of the Army Nurse Corps are not assigned, a suitable enlisted man, Medical Department, is assigned as wardmaster. The duties and responsibilities are identical with those of a nurse (see par. 203).

b. In wards to which Army nurses are assigned the duties of wardmasters are as follows:

(1) He is immediately in charge of the enlisted men assigned to the ward and responsible that they remain at their places of duty; are neat and clean about their person, in proper uniform, and properly perform the work to which they are assigned.

(2) He is specifically charged with responsibility for the police of lavatories, the segregation, transportation, and exchange of soiled and clean linen; the transportation and delivery of patients from one part of the hospital to another; the disposition and exchange of surplus and unserviceable property, and the securing of the necessary supplies and equipment from the medical supply office, the pharmacy, and other portions of the hospital.

(3) He performs such other duties as may be designated by the ward officer or nurse.

(4) Nothing in the above will be construed to interfere in any way with the authority of the nurse on the ward or other Army nurse.

119. Salutes.—See FM 21-50, and FM 21-100. All corridors and hallways are "indoors" and the exchange of salutes is not required. Detachment commanders will see that all enlisted men are familiar with the requirements of the above-mentioned manuals.

120. Sick call.—Members of the medical detachment, who desire medical attendance report to the office of the commanding officer, medical detachment, at such hours as may be designated by the commanding officer in order that their names may be placed on the sick report for examination by the proper medical officer. When their condition is so acute as to indicate the need of immediate attention,

they will be authorized to report immediately to the commanding officer, medical detachment, for the above action.

121. Noncommissioned officer in charge of quarters.—The commanding officer, medical detachment, details a permanent noncommissioned officer in charge of quarters. The hours of duty are from 7:00 AM to 7:00 PM, and from 7:00 PM to 7:00 AM. The duties of the noncommissioned officer in charge of quarters are to preserve order and discipline in the barracks of the medical detachment. He makes such inspection as to sanitation and police as the commanding officer, medical detachment, may prescribe. He is in charge of the billeting of the detachment. In his office he maintains a file of the members of the detachment, showing their bed number and place of duty. When members of the detachment absent themselves without leave, he at once notifies the detachment commander who secures the effects of the absentee (see AR 615–290). He notifies the enlisted members of the operating room staff and the enlisted men on emergency duty in the laboratory when their services are needed. He wakens the cooks at the proper time and makes the rounds of the barracks to see that the other members of the detachment are up and in condition to perform their duties at the proper time.

122. Emergency roster.—The commanding officer, medical detachment, prepares daily a roster of six or more privates or privates first class, Medical Department, who are available for emergency duty. This roster is sent to the office of the noncommissioned officer in charge of quarters where it is posted. A copy also is posted on the detachment bulletin board. The men so detailed do not leave the immediate area during their tour of duty, and keep the noncommissioned officer in charge of quarters notified of their whereabouts.

SECTION XV

ADMINISTRATIVE OFFICER OF THE DAY

123. Detail.—*a.* The administrative officer of the day is detailed by the adjutant of a general hospital from a roster consisting of all

officers designated for this duty. Notification of detail is furnished each officer 24 hours in advance.

b. Duty as officer of the day takes precedence over regular duties in cases of emergency only.

124. Tour of duty.—The tour of duty of the administrative officer of the day begins at 9:00 AM and continues for 24 hours. At the beginning of the tour the new and old administrative officers of the day report to the commanding officer or his representative. During his tour of duty the administrative officer of the day remains within the limits of the reservation and sleeps in the room provided for his use. The administrative officer of the day keeps the information office constantly informed of his whereabouts. During his tour of duty the administrative officer of the day wears the prescribed brassard on the left arm.

125. General duties.—During the absence of the commanding officer, the executive officer and the adjutant of a general hospital, the administrative officer of the day is in charge of the administration of the hospital and will be responsible for its safety and good conduct. The duties of the administrative officer of the day are of wide range and most important in character, and each officer assigned as administrative officer of the day familiarizes himself with his duties as prescribed in orders and regulations and is responsible for their proper execution. He is observant and is alert to prevent fire, theft, waste, misconduct, or neglect. He immediately corrects any breach of orders or regulations noted by him. He brings to the attention of the authorized representative of the commanding officer of the hospital any cases of serious illness or injury or any dereliction of which he may have cognizance while discharging his official duties. He responds promptly to any calls made upon him.

126. Inspection.—At least twice during his tour of duty, once between 8:00 PM and midnight and once between midnight and reveille, the administrative officer of the day inspects the entire hospital area, except the occupied wards. At each inspection he checks the prisoners in the closed or open wards, and sees that all are properly accounted for. On each inspection he visits all parts of the hospital area and inspects the garage, power plant, and the detachment barracks. During his inspections he ascertains that regulations as to conduct are observed and notes the condition of the premises inspected by him as to police and sanitation, and corrects any noted violation of regulations. He extends his inspection to include such wards as he may consider necessary in the discharge of his duties.

127. Fire marshal.—The administrative officer of the day is an assistant to the fire marshal, and during the absence of the fire marshal and the assistant fire marshal he acts as fire marshal. He insures that the night fire patrol of the area is being made. In case of fire or alarm of any kind he at once takes steps to insure the safety of life and public property and to preserve order. He reports in detail any fire which occurs during his tour of duty.

128. Duty detachment.—During the absence of the detachment commander and his commissioned assistants, the administrative officer of the day is in charge and in emergency takes whatever steps he considers necessary to insure efficiency, good conduct, and discipline of the detachment. When an enlisted man required for duty is absent or circumstances require that he be relieved from duty, if necessary he is replaced by the administrative officer of the day from a roster of men available for this duty, furnished by the commanding officer, medical detachment, posted in the officer of the day's office.

129. Confinement of persons.—The administrative officer of the day, when in his judgment it is necessary, confines any enlisted man or civilian who may be present in the hospital area or in the detention ward for safekeeping until proper action can be taken. Any officer on duty at a general hospital is authorized, when in his judgment it is necessary, to place patients in the detention ward. In each instance the person to be confined is sent to the detention ward under appropriate guard who is given an informal memorandum for delivery to the detention ward officer, requesting the person be placed in detention. In each instance the officer directing the confinement immediately furnishes the administrative officer of the day a report showing the name of the person placed in detention, the attendant circumstances, and other pertinent data, together with list of witnesses. In each instance the administrative officer of the day enters on his report names of persons confined or placed in detention, the *attendant circumstances, and all pertinent data, together with list of witnesses*, necessary to make proper disposition of the case.

130. Meal inspection.—The administrative officer of the day inspects one meal each day in the officers' mess. He inspects and eats two meals in the patients' mess and one meal and night lunch in the detachment mess. He reports to the service, and on the quantity, quality, and variations from the bill of fare of each meal inspected.

131. Escaped insane patient or prisoner.—In case of the escape of an insane patient or a prisoner the administrative officer of the

day promptly and thoroughly investigates the circumstances and makes every effort to apprehend the patient or prisoner, including notification of the civil authorities, and makes a complete report on his Officer of the Day Report.

132. Reports.—The reports of the administrative officer of the day are typewritten on the prescribed local form. As this report is filed as a part of the permanent records of the hospital, all concerned are directed that the data entered thereon are both complete and accurate. Unusual occurrences and violations of regulations are recorded under "Remarks." These data will be complete and names of witnesses, offenders, and the circumstances recorded fully and accurately. Under "Changes of Status—Duty Personnel" are entered all changes of status relating to permanent members of the command. Sufficient copies of data relative to the change of status are prepared for distribution to all offices concerned.

SECTION XVI

GENERAL SUPPLY AND UTILITIES

133. Functions.—Normally, Quartermaster Corps personnel are provided for general supply functions and for the maintenance of utilities. The duties of the officer in charge of this section of a general hospital are—

a. The procurement, storage, issue of, and accounting for all supplies and equipment necessary to the maintenance and operation of the hospital, with the exception of those supplies and equipment properly procured, stored, issued, and accounted for by the medical supply officer.

b. The supervision, maintenance, and operation of utilities.

c. The maintenance and operation of buildings, roads, walks, grounds, lighting, heating, water, sewer, and telephone systems.

d. The storage and disposition of all salvage and waste materials.

e. When operating separate from a hospital center, he is responsible for the maintenance, repair, and operation of all motor transportation.

f. Such other duties as may be specifically assigned him from time to time by the commanding officer.

134. Supplies.—*a.* The officer in charge of general supplies and utilities is charged with the procurement of such supplies and equipment of the quartermaster department as are required for the proper supply and equipment of the detachment medical patients, and for the maintenance and operation of all activities charged to this section.

b. All issues of supplies and equipment by the general supply and utilities section are governed by the following:

(1) Clothing for enlisted men is issued on requisitions submitted by the detachment commander, medical detachment, on Requisition and Receipt for Clothing in Bulk (W. D., Q. M. C. Form No. 409) for bulk issues and on Individual Clothing Slip (W. D., A. G. O. Form No. 35) for individual issues. Requisitions are prepared in duplicate, and in the case of bulk issues are submitted to the commanding officer of the hospital for approval prior to issue. When issues have been effected, the duplicate copy signed by the quartermaster is returned to the commander, medical detachment, for file. The original is retained by the quartermaster as a voucher to his stock record account (see AR 35-6560 and AR 35-6720).

(2) Nonexpendable supplies and equipment other than clothing need not be covered by formal requisition, but are issued on written informational request. Issues are made on Memorandum Receipt (W. D., Q. M. C. Form No. 487), which is prepared in duplicate, the original being signed by the person to whom issues are made and retained by the quartermaster, and the duplicate (unsigned) copy delivered to the responsible person.

(3) All issues of expendable supplies and equipment are made on requisitions submitted in duplicate and approved by the commanding officer of the hospital as follows, with the exception of those supplies used for post utilities ((*c*) below):

(*a*) Issues of cleaning and preserving materials, stationery, etc., are made at such times as ordered by the commanding officer on requisitions submitted in duplicate on Requisition and Receipt for Brooms, Brushes, Matches, Mops, Toilet Paper, Soap, etc. (W. D., Q. M. C. Form No. 411), Requisition and Receipt for Stationery and Office Supplies (W. D., Q. M. C. Form No. 412), Requisition and Receipt for Cleaning and Preserving Materials (W. D., Q. M. C. Form No. 413), and Requisition and Receipt for China and Glassware (W. D., Q. M. C. Form No. 414), and approved by the commanding officer of the hospital. Requisitions are based on allowances announced from time to time in memorandum orders and Tables of Allowances. When supplies are issued they are receipted for on original requisitions and the original is retained by the quartermaster

as a credit voucher to his accounts, and the duplicate is delivered to the responsible person to whom supplies are issued.

(*b*) All other issues of expendable articles, with the exception of those in (*c*) below, are made on Requisition (W. D., Q. M. C. Form No. 400), submitted as occasion demands. These requisitions are approved by the commanding officer and disposed of as provided in (*a*) above.

(*c*) All expendable supplies issued for the use of post utilities are shipped to the utilities officer at the end of each month on Shipping Ticket (posts, camps, and stations) (W. D., Q. M. C. Form No. 434) which is approved by the commanding officer of the hospital. It is then used as a credit voucher to the stock record account of the quartermaster.

c. The receiving of supplies and equipment by the quartermaster from organizations and individuals is governed by the following:

(1) When it is desired to turn in serviceable, nonexpendable property, it is turned in to the quartermaster and credit given for it on W. D., Q. M. C. Form No. 487. When unserviceable, nonexpendable property is turned in it is accompanied by a certificate of the responsible person setting forth the circumstances by which it was rendered unserviceable, and upon which the responsible person relies to relieve himself of the responsibility for the unserviceable condition.

(2) All expendable property when no longer required is turned in to the quartermaster for salvage or reclamation accompanied by a list of such property, and in case of clothing which has been charged against enlisted men's clothing allowance and has been dropped from accountability, the list contains the name and organization of the enlisted men to whom the clothing pertained. One copy of the list is authenticated by the quartermaster and returned to the organization commander for file with the records of the enlisted men for action of the inspector.

(3) All supplies received by the quartermaster from depots, transferred from other stations, or procured locally are received and handled in accordance with existing regulations and the following instructions:

(*a*) All articles received immediately upon receipt are carefully examined as to quality and serviceability, and checked as to quantity under the supervision of a commissioned officer.

(*b*) Upon compliance with (*a*) above, the person receiving the supplies acknowledges receipt by entering his signature on the prescribed Tally Sheet, Incoming (W. D., Q. M. C. Form No. 489)

covering the shipment in case of supplies purchased by this office, or initialing the shipping ticket covering shipment of supplies from a depot or other station. In the case of supplies purchased, the tally sheet, incoming, must be attached to the receiving report when it is submitted to the quartermaster for signature. When shipments are received from depots or other stations, the person in charge of property must initial the shipping ticket before submitting it to the quartermaster for signature. No supplies are signed for by the quartermaster until the above instructions have been fully complied with.

(*c*) All necessary papers pertaining to the receipt of property are prepared under the supervision of the principal clerk of the property section.

(*d*) Proper notations should be made on the talley sheet, incoming, or shipping ticket of any shortage, damaged goods, etc.

(*e*) The quartermaster designates in writing the personnel who are authorized to receipt for property for their respective departments.

d. (1) Providing a sales commissary is authorized, such quantities of authorized sales articles as are required to meet the demands of the personnel of the command are stocked.

(2) Sales are made only to those authorized by regulations to make purchases.

(3) The hours for sales are set by the commanding officer.

(4) Deliveries are made to personnel as directed by the commanding officer.

(5) Sales are made to patients only on orders of the ward surgeon.

(6) Providing a bakery for the hospital is authorized, it is under the direct supervision of the commanding officer. It is operated under the provisions of AR 30-2260. Issues of bread are made to organizations direct from the bakery by the chief baker who is responsible to the officer in charge of the commissary for the proper keeping of records of issues, supplies, and baking. Sale of bread to individuals will be direct from the commissary when authorized by the commanding officer.

135. Collection and disposition of salvage and waste materials.—The following instructions will govern the collection and disposition of salvage and waste materials:

a. The quartermaster, acting in the capacity of salvage officer, is charged with the collection and disposition of all salvage, waste materials, and unserviceable supplies accumulated at station.

b. Regulations governing this class of supplies require that all unserviceable articles of public property, both expendable and nonexpendable, be collected and turned over to the salvage officer for disposition.

(1) Nonexpendable property stored and issued by the Quartermaster Corps, when unserviceable, is turned over to the quartermaster accompanied by a certificate of the responsible officer, in quadruplicate, setting forth the circumstances by which the property was rendered unserviceable.

(2) All expendable articles of public property when unserviceable or no longer required, and all collection of waste materials are turned over to the salvage officer accompanied by a list, in duplicate, showing the quantity of each article delivered, duplicate copy to be signed by an authorized representative of the salvage officer and turned over to the person making delivery.

(3) (*a*) All salvage and waste materials received are disposed of in accordance with existing Army Regulations and to best interest of the service.

(*b*) Garbage from the messes operated by the hospital is disposed of by sale or otherwise, whichever is most advantageous to the Government.

136. Maintenance and repair of buildings and equipment.— The quartermaster is responsible for the proper maintenance and repair of all buildings, roads, grounds; also water, sewer, heating, and lighting systems of the hospital, and for the timely submission of estimates for adequate funds for this purpose in accordance with existing regulations. The following instructions will govern the maintenance and repair of buildings and equipment.

a. Requests for repairs to buildings, equipment, etc. pertaining to utilities are made on the quartermaster as follows:

(1) Ordinary or routine repairs are requested by verbal, telephone, or informal request direct with the utilities clerk in the quartermaster's office who issues a Work Order (W. D., Q. M. C. Form No. 106), informing the person placing the request that action will be taken.

(2) Requests for emergency repairs during regular office hours are made verbally, in person, or by telephone to the utilities clerk, or in his absence to the chief clerk or utilities foreman. Emergency request will not be made in order to gain precedence over other necessary repairs.

(3) Any unusual repairs that may become necessary after office hours are referred to the quartermaster, chief clerk, or foreman of utilities at their quarters.

b. The quartermaster arranges a priority on all requests received for repairs. Such priority on all requests will be in accordance with the approval of the commanding officer.

c. The quartermaster is responsible for repairs to all equipment stored and issued by the Quartermaster Corps and such other arm or service supplies as the commanding officer may direct. The quartermaster does not receive requests for repairs to medical equipment. These requests are made on the medical supply officer, who is accountable for that class of equipment.

d. If within a reasonable length of time requests for repairs do not receive proper attention or repairs are unsatisfactory, a report of such fact is made to the quartermaster.

e. No changes in any of the utilities systems in the buildings are made without prior authority of the commanding officer or the quartermaster.

137. Maintenance and operation of utilities.—The quartermaster is responsible for the proper maintenance and operation of utilities pertaining to the Quartermaster Corps (and Signal Corps if any), and for the submission of adequate estimates of funds required for this purpose in accordance with existing regulations; also, for the submission of requisitions for fuel and other supplies required for maintenance and operations.

a. Special instructions are issued as to personnel, their duties, etc., for the efficient operation and maintenance of power plants at such time as they are taken over by the Army for the purpose of establishing a general hospital.

b. The quartermaster usually is appointed fire marshal by the commanding officer and instructions as to fire prevention and action necessary in case of fire are issued at such time as buildings are taken over by the Army for hospital purposes.

c. The ice plant is under the superivsion of the quartermaster and deliveries are made as directed by the commanding officer.

d. The various workshops operated under the supervision of the quartermaster are governed by the following instructions:

The foremen of all utilities shops such as plumbing shop, electrical shop, painting shop, etc., are responsible for the proper functioning of their respective shops and for the conservation and use of all materials and supplies furnished them for the performance of their duties.

138. Transportation.—*a.* The quartermaster is responsible for the maintenance and operation of all motor transportation consisting of ambulances, passenger vehicles, trucks, etc., and for the issuance

of such requests for rail transportation as are required for travel on competent orders of personnel of the hospital, including patients returning to duty; for the preparation and arrangement of shipment of all freight or express shipments, including public and personal property, the shipment of which is authorized by regulations.

b. The following instructions govern the issuance of rail transportation to personnel departing the hospital and preparation and shipment of household goods and other property from the hospital.

(1) The quartermaster, upon receipt of competent orders, issues transportation requests to cover such rail transportation and sleeping car accommodations required for personnel departing the hospital. He is guided in the issuance of such transportation by instructions contained in AR 30–905, 30–910, 30–920, and 30–925.

(2) All individuals contemplating travel on an official status should acquaint themselves with instructions contained in the above-mentioned Army Regulations.

(3) The quartermaster, in addition to the issuance of transportation requests for travel and sleeping-car accommodations, including dependents where authorized, makes all necessary reservations whenever requested to do so by the traveler.

(4) The quartermaster, in the case of movement of tuberculous, insane, and other patients, prepares itineraries, secures through reservations, and makes such arrangements with the carriers as are necessary to insure the utmost comfort for the travelers.

(5) Whenever the shipment of remains of a deceased person with an attendant is authorized, the quartermaster issues the necessary transportation requests to cover the transportation of the remains and attendant as provided in AR 30–920, 30–955, and 30–1830.

(6) Whenever the shipment of remains by express is directed the quartermaster makes the necessary arrangements with the carrier for shipment. Shipment of remains by express is to be covered by a Government bill of lading.

(7) The undertaker employed by the quartermaster is held responsible that all remains for shipment are prepared in accordance with existing laws.

(8) All public property for shipment from the hospital is turned over to the quartermaster for shipment, accompanied by a request for shipment, containing the proper address of consignee and such other information as is necessary for him to take intelligent action and insure shipment.

(9) The quartermaster is governed in handling the shipment of personal property by instructions contained in AR 30–960.

CHAPTER 3

PROFESSIONAL SERVICES

SECTION I

GENERAL

139. Constitution.—The medical, surgical, laboratory, roentgenological, and dental services constitute the professional division. They may be divided into sections as desired by the chief of service and approved by the commanding officer within the limitations of personnel outlined in Table of Organization 8–507.

140. Chief of service.—The chief of each service maintains supervision over the entire service, and makes recommendation for the assignment of assistants allotted him. He is responsible for the administration, sanitation, and police of wards, section, and other activities pertaining to his service. The chief of the service is also responsible that the clinical record is complete and correct before transmitting it to the registrar.

141. Chiefs of sections.—Each of the sections is conducted by a designated medical officer who is known as the chief of section. He is responsible to the chief of the service for the administration and operation of his section and the care and treatment of all cases in that section.

142. Reports.—The chief of the medical service and the chief of the surgical service submit at the end of each month a consolidated report in duplicate of the number of out-patients treated and the number of treatments administered to out-patients in the various sections of their services. With this object in view they cause every chief of section in which out-patients are treated to maintain an out-patient index in conformity with the requirements of AR 40-1025.

143. Police and sanitation.—*a.* Chiefs of professional services and the heads of administrative departments are responsible for the police and sanitation of all activities pertaining to their services or departments. They institute such measures as may be necessary to maintain departments and services of the hospital in a condition constantly ready for inspection.

b. Chiefs of professional services hold chiefs of sections and ward officers responsible for the police and sanitation of their clinic rooms or wards. With this object in view, chiefs of services require them to make at least one daily inspection of their wards or clinics, and to take immediate action to correct the irregularities discovered.

144. Consultations.—*a.* Each chief of service considers all "requests for consultation" made to and within his service, approving or disapproving as he deems best. In cases of approval, he designates the consultant by name.

b. Consultation is not ordinarily requested until a complete history has been taken and a thorough physical examination has been made, together with such routine laboratory data as would be helpful to the consultant in forming an opinion on the case. Emergency requests for consultations are considered and acted upon with the least practicable delay.

c. Medical consultants, after completing their examinations, enter their opinions in writing upon appropriate blanks to be attached to the patient's clinical record, together with any recommendations which they may desire to make.

SECTION II

WARD OFFICER

145. General.—Ward officers are assigned to duty by the chief of service. They are responsible to the chief of service for the administration, sanitation, equipment, and discipline of their wards, the treatment of patients therein, and the proper performance of duty by assistant ward officers, nurses, and attendants, including civilian employees. Unless excused by proper authority or required by their duties to be elsewhere, they are present in their wards during hours designated by the commanding officer. They visit their wards sufficiently often during the period the night personnel are on duty to assure themselves that patients are being properly cared for, that the night personnel are efficient, and that the ward is being conducted in conformity with regulations. They hold formal sick call at 9:00 AM daily, or as soon thereafter as practicable, at which time they personally see each patient in the ward and make inquiries of the patients to satisfy themselves as to their condition.

146. Administration.—*a.* Ward administration is a serious and extremely important duty of a ward officer, a responsibility which cannot be subordinated. The professional attention, care, and treatment of patients are of primary importance, but such care and treatment cannot be properly accomplished unless efficient administrative methods are maintained.

b. Absolute cleanliness, orderliness, and quiet are the first essentials of ward administration, and can be obtained only by the constant vigilance of officers, noncommissioned officers, nurses, and others in authority.

c. Careful and thorough inspections must be made at least once daily, and immediate action taken to bring about the correction of

irregularities so discovered. Ambulatory patients whose physical condition permits are required to assist in the ward police provided they are designated for that purpose by the ward officer.

d. The discovery and elimination of vermin requires constant attention of ward officers. Roaches and bedbugs are constantly present and must be combated continuously. Roaches are to be found more commonly in diet kitchens and toilets, and are readily discoverable during the night hours. They can be eliminated by the distribution of sodium fluoride or other insecticide. Bedbugs are usually found along the seams of mattresses and in the bed springs. When bedbugs are discovered the fact should be reported immediately to the hospital inspector who prescribes the method to be used for their elimination.

e. Ward officers assure themselves that patients have sufficient toilet articles (comb and brush, tooth brush, tooth paste and shaving utensils) in their possession, that their teeth are cleaned at least once daily, and that they bathe or are bathed at proper intervals.

f. Patients other than those on an officer status, are required to wear hospital outer clothing while in the hospital. Except in the case of patients on an officer status, personal clothing, with the exception of shoes, socks, underclothes, and head covering, is deposited in the hospital clothing room. Patients wear a bathrobe properly belted while away from their wards unless convalescent suits are available. Ward officers are responsible that hospital clothing worn by patients is serviceable, neat, and scrupulously clean.

g. Clinical thermometers when not in use are kept completely immersed in 2 percent solution of phenol. Before being used thermometers are taken from the phenol solution and completely immersed in denatured alcohol and thoroughly washed and wiped off with cotton before being placed in patient's mouth. After removal from patient's mouth, thermometers are thoroughly washed and returned to the phenol solution. This procedure is repeated after each successive patient. Any other method of sterilizing clinical thermometers is prohibited.

h. Lavatories are maintained in a constant state of cleanliness and order. Steps are taken to prevent accumulation of soiled towels, pajamas, etc. A bucket partially filled with water is kept habitually in a convenient place in each lavatory for the reception of refuse such as cigarette butts. Bedpan covers (fabric) are used to conceal bedpans and urinals when in transit to and from the patient or whenever it is necessary to leave the utensil in the vicinity of the patient's bed. A sufficient number of bedpan covers are kept neatly folded and ready for use on each rack containing bedpans or urinals.

147. Patients.—*a. Control.*—(1) Ward officers should impress upon their patients that they are interested in their welfare, anxious to make them comfortable, and to improve their physical condition. They should endeavor to explain to them the necessity and importance of certain ward regulations, diagnostic procedures, therapeutic procedures, etc., to the end that the patients are relieved of the mystery, fear, and suspicion so often present in the minds of those who are subjected to a hospital environment. They should not hesitate to discuss the patient's condition with him, and to give him such information relative to the progress of his case, results of laboratory procedures, diagnoses, etc., as may assist him to gain an insight into his physical condition. The majority of patients appreciate frankness in these matters and will cooperate accordingly.

(2) Ward officers are responsible for the discipline of patients in their wards. Patients committing minor offenses will be punished by confinement to bed, restriction of privileges, etc. Major offenses or repeated minor offenses will be reported to the commanding officer, detachment of patients, for disciplinary action.

b. Complaints.—Ward officers carefully investigate all complaints made to them by patients no matter how trivial the complaint may appear to be, and in the event the complaint is justified take immediate steps to correct the irregularity. Irregularities that are beyond the power of the ward officer to correct are immediately reported to the adjutant.

c. Privacy.—Ward officers assert every effort to preserve the privacy of patients insofar as possible. Patients in open wards are protected by screens while undergoing dressings, spinal punctures, venipunctures, etc., while being bathed, and while the bedpan is being used.

148. Medicine and medical treatment record.—*a.* Medicines and medical treatment of patients are prescribed only by medical officers. Dental treatment is prescribed by dental officers. A book of record is maintained in each ward known as a "ward order book", containing treatment record and nurses' report sheets, temperature, and pulse and respiration sheets. Methods of maintaining this book are as prescribed from time to time in hospital memoranda.

b. A medication sheet is maintained in every ward of the hospital in which patients are receiving medication. This form shows the name of the patient, the character of the medication, and time of administration, entries of which are made in a space provided for that purpose on the form. This form is kept habitually fixed to the inner side of the door of the ward medicine cabinet. The nurse

in charge of the ward is responsible that it is kept up-to-date at all times.

149. Alcohol and narcotics.—All morphine, cocaine, codeine, alcohol, and alcoholic liquors, and other habit-forming drugs, to include barbital, luminal, sulphonal, trional, and similar products, are kept securely locked and the amounts on hand limited to actual necessity. The keys are kept habitually in the personal possession of a member of the Army Nurse Corps or a medical officer. In every ward where morphine, cocaine, codeine, and whisky are dispensed a record is maintained. Ward officers assure themselves that this record is properly and accurately kept and on the 10th, 20th, and last day of each month audit the record and certify as to its correctness.

150. Visitors.—Ward officers are responsible that visitors are not permitted in wards at hours other than the regular visiting hours unless permission for the visit has been previously obtained.

151. Bulletin boards.—Ward bulletin boards are for the purpose of disseminating information and orders to patients. They should contain no matter other than necessary to meet this requirement. The contents of these bulletin boards will be neatly arranged and kept free from obsolete and extraneous matter.

152. Ward attendants.—*a.* Ward attendants are assigned to wards by the detachment commander in numbers specified by the commanding officer. One ward attendant is designated as wardmaster by the detachment commander. Under the supervision of the ward officer and ward nurses, wardmasters have general charge of the ward attendants, and are held responsible that they perform their duties satisfactorily, are neat and clean about their person, and are in the prescribed uniform at all times. Ward officers instruct ward attendants in their duties and require them to exercise gentleness, kindness, and tolerance in dealing with patients.

b. Ward officers give their personal attention to the supervision of duties which require that ward personnel leave their wards and so direct and coordinate the movements of personnel as to avoid unnecessary absences from their wards, particularly before the hour of 10:00 AM.

153. Property.—*a.* Ward officers are responsible for all property in their wards. Transfer of responsibility is in accordance with paragraph 59. If no shortage is discovered the succeeding officer signs and forwards the memorandum receipt to the medical supply officer within 48 hours after he has assumed charge of the ward. When a shortage exists report is made to the medical supply officer, who adjusts such discrepancies as are possible; the remainder are placed on report

of survey by the former ward officer. Overages found are listed and turned in to the medical supply officer for adjustment.

b. Requisitions for supplies are signed by the ward officer and forwarded to the medical supply officer and the ward officer is held accountable that only such articles are requested as are needed. Requisitions are prepared on the typewriter when practicable and include the item number and conform to the nomenclature published in the Medical Department Supply Catalog. Requisitions are based on the needs of 1 week and supplies will not be accumulated. Emergency requisitions are not forwarded for supplies unless such emergency actually exists and then only for such amount as required to meet the emergency.

c. Property is checked on the first day of each month, except when this day falls on Sunday or a holiday, in which case the check is made on the following day. Result of the check showing all shortages and overages is sent to the adjutant by noon of the following day.

d. Requests for purchase of nonstandard supplies are made to chief of service in accordance with paragraph 60.

e. Ward officers are responsible for the proper care and economical use of all property in their wards. Breakage and damage not due to fair wear and tear is acted on in accordance with AR 35-6640.

f. The use of hospital bedding and clothing for cleaning purposes is forbidden.

154. Diagnosis report.—*a.* As soon as a diagnosis of a patient is established, the ward officer completes a diagnosis card and transmits it without delay to the registrar. Similar action is taken whenever there is an addition or a change in diagnosis; an operation or complication which should be reported (AR 40-1025).

b. Diagnosis will conform as far as practicable to the nomenclature of diseases as set forth in AR 40-1025.

155. Directory board.—A ward directory board of the standard type issued by the medical supply officer is maintained in the ward officer's office in every ward of the hospital. This board shows the register number, surname, christian name, grade, organization, religion, and date of admission of the patient. Slips furnished by the receiving office are used for this purpose. Ward officers are responsible that this directory is kept accurately up-to-date at all times.

156. Report of unusual occurrence.—*a.* Report is made of any unusual occurrence in which a patient is concerned, that is, suicide or attempted suicide, falling from bed, injury inflicted by another patient, injury due to accident within the hospital, burns from hot water bottle or electric appliance, error in the administration of medication, etc. In short, any unusual occurrence which might have been

detrimental to the patient or might constitute a reason for justifiable complaint.

b. This report is prepared in duplicate, Report of Unusual Occurrence, as soon as possible after the occurrence. One copy is sent without delay to the adjutant, and the other to the chief of service concerned. If the occurrence to be reported is at a time other than duty hours, the reports are submitted at 9:00 AM the following morning.

c. If the unusual occurrence is in a ward, reports are prepared and forwarded by the ward officer, or in his absence, by the nurse in charge. In other instances report is prepared and forwarded by the officer or nurse who first has cognizance of the occurrence.

157. Release of information.—*a.* Requests for information regarding patients by newspapers, press bureaus, radio stations, and similar organizations are courteously referred to the executive officer or the adjutant for reply. All *proper* information regarding the condition of patients is freely given to the above-noted organizations upon their request. When information of this character is given by other than the executive officer or the adjutant, a brief statement in writing covering the information given and to whom is furnished the adjutant so that the information given out by all parties will be as uniform as possible. The question as to what is proper information must be left to the good judgment of the person imparting it, but this should be interpreted liberally.

b. When calls are received over the telephone for information regarding patients, they are referred to a commissioned officer for answer.

c. Requests received outside of regular duty hours are referred to the appropriate professional officer. If, at the time calling, the information is not available or the proper officer is engaged in the care of a patient, the party calling should be asked to call back in about 20 minutes and notified that he will then be given the information requested.

SECTION III

DETENTION WARD

158. Ward officer.—An officer of the Medical Corps is designated as ward officer. The officer so designated is responsible for the examination, care, treatment, diet, and comfort of all patients assigned to the ward. He is responsible that sufficient and proper instruments, appliances, dressings, and drugs are on hand to facilitate the examination and treatment of patients in the ward and to prevent the necessity of reporting patients to clinics. If a patient requires treatment that can be given only by a specialist or if consultation is desired, the ward officer is authorized to refer such patients to the appropriate service or section for examination or treatment in accordance with existing regulations. Such references are kept to a minimum consistent with the proper treatment or examination of patients. Officers designated as consultants and those treating prisoner patients hold the consultations and administer treatments in the detention ward whenever practicable. The ward officer is not relieved of the responsibility for the care and treatment of patients referred to other services or sections but keeps himself fully informed as to the progress of the case and assures that the prescribed treatment is regularly received. He is responsible that all pertinent data relating to the physical examination, the care and treatment of the patient are recorded in the clinical record in accordance with existing instructions.

159. Wardmaster.—A competent member of the Medical Department is detailed as wardmaster. He is provided with such assistance as may be necessary. He is responsible to the ward officer for the execution of all instructions relating to the professional care and treatment of patients.

160. Admission procedure.—All prisoner patients admitted to hospital are placed in the detention ward by the admitting officer who furnishes the ward officer written orders for their detention. Upon admission patients don hospital clothing and all clothing or baggage in their possession is taken from them, listed on W. D., M. D. Form No. 75 and stored in the patients' baggage room. Clothing or baggage of any description is not permitted to remain in the detention ward. In the presence of the ward officer, or in his absence, the administrative officer of the day, all persons admitted to the ward are searched and any funds, valuables, matches, knives, weapons, or other dangerous articles of any description are taken from them, listed in accordance with paragraph 86, and turned over to the custodian of patients' funds and valuables until discharged from hospital. Clothing and baggage taken from the patient are inventoried by the wardmaster who, in the presence of the ward officer or

the administrative officer of the day, carefully lists the articles on W. D., M. D. Form No. 75, in duplicate. Specific description is noted in cases of unusual items to permit ready identification. The officer witnessing the inventory verifies and signs both copies. Both copies are sent to the patients' baggage room. The noncommissioned officer in charge of the patients' baggage room checks the clothing and if correct with the patient's property card signs both copies. The original is filed in the patients' baggage room and the duplicate returned to the ward officer.

161. Daily inspection.—Under the direction of the ward officer a search of the entire ward is made daily for matches, weapons, or other dangerous objects that prisioners may have concealed. The windows, doors, and all parts of the ward are thoroughly inspected at least twice daily.

162. Medicine.—No medicine is given to patients for self-administration. Each dose of medicine prescribed is administered by the wardmaster or his assistant. No medicines or bottles are left in the ward. A book of record is maintained in the ward known as the "ward book" in which the ward officer or other officer prescribing records all orders for medicines and treatment. All entries are authenticated by the proper officer's initials or signature. A narcotic and alcoholic register is maintained in the ward. Only sufficient medicines, drugs, and other preparations are kept on hand to meet the immediate requirements of the ward and all such drugs and other preparations are securely locked in the medicine cabinet which is kept in the locked ward office.

163. Meals.—Meals are served in the ward, except that the ward officer may authorize convalescent patients to eat in the mess hall, in which case a guard is provided. Patients under observation for mental disease, insane, or having communicable dieseases are not permitted to go to the mess hall.

164. Clinical treatment.—Patients referred to services or sections are examined and treated in the detention ward unless it is wholly impossible to administer properly the treatment therein, in which case the officer responsible for the examination or treatment notifies the ward officer as to the hour he desires the patient. The ward officer arranges that such patients are promptly reported and the officer responsible for the examination or treatment arranges so that it is given immediately upon the arrival of the patient. The ward officer notifies headquarters whenever treatment is not given promptly at the designated hour. Officers treating patients in the

detention ward visit such patients at least once daily and keep the ward officer informed as to the progress of the case and take all steps necessary to expedite the discharge from hospital of such patients.

SECTION IV

NEUROPSYCHIATRIC SECTION

165. Organization.—The neuropsychiatric section operates as a part of the medical service under the direction of the chief of medical service. The senior medical officer on duty with the section is known as the chief of the neuropsychiatric section, and with his commissioned assistants is responsible for the care and treatment of all neuropsychiatric cases in the hospital. If cases are in wards other than those of the neuropsychiatric section, the chief of section cooperates with the ward officer directly in charge of those patients, giving such advice and assistance as may be necessary.

166. Wards.—*a.* Such wards as are designated by the commanding officer are closed (locked) wards for the treatment of mental patients.

b. Such open (unlocked) wards as are designated by the commanding officer are used for the treatment of suitable neuropsychiatric patients.

c. Responsibility for conduct of closed wards is that of the nurse in charge, or in her absence, the wardmaster, who is held responsible for the execution of any special instructions of the ward officer, and for the proper observance of all routine regulations or general instructions pertaining to either the personnel on duty on such ward or the conduct of the ward.

167. Enlisted attendants.—The commanding officer, medical detachment, is charged with the assignment of a sufficient number of enlisted men as attendants. Enlisted men are selected because of their

adaptibility for this special duty. They are assigned with a view to permanency and are changed only for cogent reasons. There is at least one noncommissioned officer on duty in this section at all times. No ward is left without at least the minimum safe number of attendants as determined by the chief of section. No attendant leaves his ward during duty hours until he has been granted such permission by the wardmaster, and no wardmaster leaves his ward except by authority from the noncommissioned officer in charge of section.

168. Admission procedure.—Patients admitted through the receiving office and from other wards are delivered at the office of chief of neuropsychiatric section. In cases of patients admitted to closed wards the admission routine pertaining to the search for valuables (as prescribed in par. 86) is carried out by a medical officer on duty in this section, or, in his absence, by the medical officer of the day, and all matches, weapons, or dangerous instruments are removed and disposed of as prescribed by regulations dealing with property of patients.

169. Daily inspection.—An inspection of all parts of each closed ward is made daily between 7:00 AM and 9:00 AM by the nurse in charge and the wardmaster for all property or dangerous objects which patients may have concealed. The windows, doors, and all parts of the ward are thoroughly inspected at frequent intervals each day by them to insure that the security of the ward is being maintained.

170. Check of patients and keys.—*a. Patients.*—(1) Nurses and wardmasters of all wards, upon coming on duty, assure themselves that all patients are present and make immediate report to the noncommissioned officer in charge of section of any absentees, and further note same on daily morning report of ward. Upon relief of the day noncommissioned officer by the night noncommissioned officer, they together make a careful check of all patients on closed wards and the same procedure applies on relief of the night noncommissioned officer by the day noncommissioned officer. In addition to the above, the patients on the closed wards are checked and the number verified by the wardmaster hourly, day and night.

(2) No matches are furnished patients on closed wards or allowed in their possession.

(3) The wardmaster searches patients for weapons or implements upon their return to the closed wards after any period of absence.

(4) All incoming packages or bundles intended for patients are searched by a nurse or noncommissioned officer in the presence of the patient, and all forbidden articles removed and disposed of in accordance with existing regulations.

b. Keys.—(1) The noncommissioned officer in charge of section is responsible for the issue and record of keys to locked wards. Surplus keys are kept in a locked compartment in section office.

(2) Enlisted attendants are cautioned against the careless handling or loss of keys and care is taken to prevent any patient obtaining possession of keys. Loss of keys is reported immediately to the noncommissioned officer in charge.

171. Medicines and poisons.—All medicines and poisons are kept in securely locked cabinets and the key is kept in the possession of the nurse or noncommissioned officer. No medicines are given to patients for self-administration. Each dose prescribed is administered by a nurse or by a noncommissioned officer. Patients are not permitted in ward offices where medicines are kept unless the ward officer or nurse is present.

172. Treatment of patients.—*a.* It must be carefully borne in mind that patients in this section (and especially in closed wards) are mentally ill. They are to be treated with consideration and kindness at all times. Attendants are forbidden to strike or maltreat a patient in any manner and any attendant so offending is punished. Each attendant reporting for duty on this section signs a statement that he has read and understands the regulations pertaining to this section.

b. Under no circumstances are arms, clubs, or weapons of any description permitted on a closed ward.

c. No form of mechanical restraint, seclusion, or cold showers is applied as punishment. Restraint or seclusion for therapeutic reasons is applied only upon the written order of a medical officer, and under the direction and supervision of the nurse in charge. The nurse keeps a record of the time of applying and of removing the restraint or seclusion. Nurses and enlisted attendants familiarize themselves with the use of the restraint apparatus. A patient in restraint or seclusion is carefully watched.

d. In case of sudden violence of a patient or of injury to a patient or to an attendant, a medical officer will be notified immediately.

e. No patient from a closed ward leaves the neuropsychiatric section except with permission of a medical officer and in the custody of one or more attendants. Not more than two patients leave the closed neuropsychiatric section in charge of one attendant. The attendant is thoroughly instructed not to lose sight of his patient at any time until he is returned to the neuropsychiatric section unless relieved of his responsibility by an officer or a noncommissioned officer on duty in that section. No officer, nurse, or attendant in

any clinic or department where cases are sent will give instructions contrary to the above.

f. No patient is taken from the closed neuropsychiatric section without knowledge of the nurse in charge or ward nurse, and she enters in a record book the name of the patient, time of departure, time of return, destination, and name of approving medical officer.

173. Visitors in closed wards.—Patients on closed wards ordinarily meet visitors in the visitors' room, such visits to be under observation of an attendant when deemed necessary by the ward medical officer.

174. Night nurse.—The night nurse in charge remains in the office of the closed ward when not actively engaged in her ward duties. The night wardmasters and attendants at all times remain on ward proper unless relieved by the noncommissioned officer.

175. Shaving and hair cutting.—Shaving and hair cutting of patients on closed wards are done by an attendant detailed for duty and in no case is a patient permitted possession of barber equipment.

176. Prisoner status patients.—Patients on a prisoner status or those awaiting general court martial charges confined on the closed neuropsychiatric section are not sent off the section except to visit a clinic or for other authorized official purposes. In such cases each is accompanied individually by one or more attendants, the number to be determined by an officer.

SECTION V

LABORATORY SERVICE

177. Chief of service.—The senior medical officer assigned to the laboratory service is known as the chief of laboratory service. His duties in general are—

a. General charge of the laboratory.

b. To supervise the performance of such examinations as are requested by ward officers, and report findings directly to the ward officer concerned.

c. General charge of the morgue, including care of the bodies of deceased persons (until turned over to the proper undertaker), per-

formance of post mortem and biopsy examinations, preparation of protocols and biopsy reports, and the preservation, classification, and disposition of gross specimens (see also par. 106).

178. Emergency detail.—There is at least one commissioned officer in the laboratory during the period of regular duty, and a competent enlisted technician is on emergency duty throughout the 24 hours.

179. Examinations.—*a. Record.*—A record of all examinations made is maintained in the laboratory. Blood donor index cards, autopsy protocols, and card index of surgical pathological reports and basal metabolism reports are permanent. All other duplicate laboratory reports are kept for a period of 3 months and then destroyed.

b. Procedure.—(1) *General.*—(*a*) Requests for laboratory examinations are made in duplicate on the Medical Department blank forms provided for that purpose. (W. D., M. D. Forms Nos. 55L, 55L–2, 55L–3, 55L–5, 55L–7, 55L–8, 55L–9, and 55M.) Requests for examinations not included in the printed Medical Department forms are made on W. D., M. D. Form No. 55L (Clinical Record, Laboratory Reports). A check mark beside any particular item or items appearing on the form may be used to indicate which examinations are desired, or additional items may be added when required. Requests which are not checked by item are given the routine examinations. The officer requesting the examinations checks and authenticates every request by signing his initials.

(*b*) Routine specimens and patients requiring laboratory tests are sent to the laboratory not later than 9:30 AM except Sundays and holidays.

(*c*) Requests for emergency examinations receive prompt attention and have precedence over routine work. All such requests are initialed by the responsible officer requesting the examination.

(2) *Wassermann test.*—Blood specimens for routine Wassermann tests are collected on designated days. Patients in the hospital whose condition permits are sent to the laboratory between 7:30 and 9:30 AM except as noted in (1)(*b*) above. The blood of bed patients and all female patients in the hospital is collected in the wards by laboratory personnel. Requests for bed patients bear the notation "bed patient" and the number of the bed, and are forwarded to the laboratory before 9:00 AM. Requests for Wassermann tests are prepared on W. D., M. D. Form No. 55L–3. All first requests for Wassermann tests are accompanied by the Wassermann card, Record

of Serological Reactions for Syphilis (W. D., M. D. Form No. 97), properly executed and signed by a medical officer.

(3) *Spinal fluid.*—Spinal fluid for serological examinations is collected by an officer designated by the chief of the section concerned. Specimens accompanied by the proper request are delivered to the laboratory immediately after removal from the body.

(4) *Darkfield examination.*—Patients requiring darkfield examinations are reported to the laboratory.

(5) *Tissues for histopathologic examination.*—All tissues are accompanied by W. D., M. D. Form No. 55M properly executed. All tissues are placed in 10 percent formalin (4 percent formaldehyde solution) which can be obtained at the laboratory. Specimens so preserved are delivered in person to a member of the laboratory staff. Specimens too large for the ordinary specimen bottles are wrapped in moist gauze and paper and delivered to the laboratory as soon as practicable after removal. When frozen sections are desired the pathologist is notified *in person* as far in advance as practicable.

(6) *Basal metabolism determinations.*—Requests for basal metabolism determinations are prepared on W. D., M. D. Form No. 55L and are sent to the chief of service concerned for approval before submitting them to the laboratory. The chief of the laboratory service, or his representative, informs the patient's ward officer of the date and hour for the determination.

c. Use of proper containers.—Proper containers for the collection of specimens are used in every case. Such containers may be obtained at the laboratory only in sufficient numbers to supply immediate needs. All specimens are labeled with name of the patient and ward. The use of adhesive plaster is prohibited for this purpose.

180. Blood transfusions.—*a.* Full responsibility for the inauguration and control of an efficient method of providing blood donors is placed on the chief of laboratory service. He selects a sufficient number of donors and keeps an available list of them in his office. He assures himself that the required monthly physical and periodic serological examinations are made, and prepares written instructions governing the method of selection of donors, the necessary medical supervision, and the manner of keeping records. For this purpose a card index system is established.

b. Physical examinations of donors at the time of donation are made by an available medical officer who over his signature notes the results in the space provided on the transfusion record.

c. Requests for blood transfusions are prepared in triplicate and sent to the chief of laboratory service. Upon receipt of such request the chief of laboratory service, or his representative, types the patient. He then secures a suitable donor and accomplishes the necessary cross check of types and such other serological procedures as may be indicated.

d. The officer requesting the transfusion has the indicated physical examination accomplished with emphasis on the presence of venereal or other disease. In each instance the temperature is taken. Results, including cause for rejection if found, are entered over his signature. He then ascertains from the chief of the surgical service or his representative the name of the medical officer who is to perform the transfusion, and the time and place of operation. At the time designated he sends the donor and the patient to the place indicated.

181. Autopsies.—Post mortem examinations are made by the chief of the laboratory service or his assistant on the written authority of the commanding officer.

182. Preservation of specimens.—Valuable and interesting specimens obtained in operation or autopsies are preserved and forwarded to the Army Medical Museum accompanied by pertinent data (AR 40-310).

183. Disposition of bodies.—*a.* Bodies of deceased persons are prepared properly and removed to the morgue as required by paragraph 103. Bodies of deceased persons committed to the morgue are placed there in correct posture. Care is exercised to prevent turning of the head, extreme flexion or extension of the neck, or malposition of extremities. Undue pressure by winding sheets, especially about the face, is avoided. During routine duty hours this is a responsibility of the chief of laboratory service. Outside of routine duty hours the responsibility rests on the officer who determines the fact of death. The chief of the laboratory service or his representative is responsible for the care of bodies held in the morgue, and turns them over to the undertaker only on the written authority of the registrar or the administrative officer of the day.

b. The person removing the bodies from the morgue acknowledges receipt thereof upon the registrar's order authorizing removal. This record is filed in the laboratory.

SECTION VI

ROENTGENOLOGICAL SERVICE

184. Chief of service.—The senior officer assigned to duty in the Service is in charge thereof and is known as the chief of the roentgenological service. He is directly responsible for its efficiency.

185. Examinations.—*a. Requests.*—Requests for examination are prepared in duplicate on W. D., M. D. Form No. 55 K–2. The officer requesting the examination states the part to be examined, the provisional diagnosis, and signs the request. Requests for emergency or bedside examinations are plainly marked "emergency" or "bedside" on the face of the form. Requests for dental roentgenological examinations are sent to the chief of the dental service. Requests for all other examinations are sent to the roentgenological service in accordance with instructions and the schedule of examinations prepared by the chief of the service.

b. Reports.—Reports of examinations are prepared in duplicate, one copy being sent to the officer requesting the examination for file with the patient's clinical record, and the other copy filed in the roentgenological service.

186. Records and roentgenograms.—A record of every roentgen examination, roentgen therapy, and radium therapy is filed in the roentgenological service. Authority for the destruction of old roentgenograms is obtained from the commanding officer. Reports and roentgenograms are not furnished to patients without the authority of the commanding officer. Demonstration of roentgenograms by the chief of the service or his assistant is held at a designated hour. Officers are urged to take advantage of this consultation hour.

187. Roentgen and radium therapy.—*a. Roentgen.*—Requests for roentgen therapy are prepared on W. D., M. D. Form No. 55 K–3 and forwarded to the chief of the roentgenological service. The clinical record is sent by messenger to the chief of the service when the patient reports for the first treatment. Upon completion of a series of treatments the chief of the service or his assistant sends to the ward officer a record of the treatment.

b. Radium.—The chief of the roentgenological service or his commissioned assistant has charge of all radium and personally supervises all radium therapy. The radium when not in use is kept in the radium safe. Requests for radium therapy are prepared on W. D., M. D. Form No. 55 K-3 and forwarded to the chief of the service. Upon completion of a series of treatments the officer supervising the treatment sends to the ward officer a record of the treatment. The ward officer assumes responsibility for the care of radium when it is in use on the wards. In such cases the chief of the roentgenological service or his assistant sends by messenger to the ward officer a radium treatment card to be attached to the foot of the patient's bed and instructions for the care of the radium and the patient.

188. Preparation of patient.—The preparation of patients for the various roentgenological examinations is as directed by the chief of the roentgenological service (see sec. VIII, ch. 4).

SECTION VII

DENTAL SERVICE

189. Organization.—The dental service constitutes a unit of the professional division of the hospital. It includes all officers of the Dental Corps, members of the Army Nurse Corps, enlisted men assigned to the dental service, and such other personnel as may be assigned to it by proper authority. The dental service is subdivided into the following sections:

a. Operative.
b. Prosthetic.
c. Oral surgery.

190. Chief of service.—The senior officer assigned to duty in the dental service is in charge of that service and is known as the chief of the dental service. His duties and responsibilities in general are—

a. General supervision over the entire service.

b. The issuing of such orders and formulation of such regulations for the operation of the service as he may consider necessary.

c. The assignment of officers on that service to specific duties.

d. Responsibility for the administration, sanitation, and police of operating rooms, clinics, and other activities pertaining to his service.

e. Responsibility for the technical training of enlisted and civilian personnel assigned to the dental service.

f. Responsibility for the performance of the annual survey of enlisted men of the various duty detachments as prescribed in AR 40–510.

191. Chief of section.—Each of the sections listed in paragraph 189 is conducted by a designated dental officer who is known as the chief of section. He is responsible to the chief of service for the administration and operation of his section and for the care and treatment of all cases in that section.

192. Property officer.—An officer of the Dental Corps is detailed by orders from headquarters on recommendation of the chief of the service to assume responsibility for property, drugs, and materials issued to the dental service.

193. Dental treatment.—*a. Precedence.*—Precedence in dental treatment is given as prescribed in AR 40–510, under the following conditions:

(1) Persons requiring emergency treatment.

(2) Persons not requiring emergency treatment.

(*a*) Patients in hospital for dental treatment only.

(*b*) Patients in hospital with dental involvement a factor in their hospitalization.

(*c*) All other persons requiring treatment.

b. Examination of patients in hospital.—Except cases of emergency, patients in hospital who require dental examination and report or dental treatment are sent to the dental clinic daily accompanied by dental consultation request. This request shows patient's name, status, etc., whether referred for treatment or examination or both, the patient's diagnosis, his probable duration of hospitalization, together with any remarks pertinent to the case with special reference to the presence of syphilis in the infectious state, whether the case is of an emergency nature and requires immediate attention, and whether bedside examination is required. This form is not entrusted to the patient but delivered to the office of the chief of the dental service at the time the patient reports. Upon completion of the examination of patient, the dental officer making the examination notes the result on both the original and duplicate of the dental consultation request, returns the original to the ward officer and files the duplicate with the records of the dental service. The routine

dental examination of patients in hospital is not contemplated and is not requested unless there is an occasion for such examination. Leaves, furloughs, or passes which might interfere with dental treatment are not granted without consultation with the chief of the dental service.

c. Out-patients.—(1) Officers and members of the Army Nurse Corps on duty at the hospital who require dental treatment report directly to the chief of the dental service.

(2) Enlisted men of the various duty detachments who require dental treatment have their names placed on the daily sick report and report to the officer in charge of dispensary. That officer refers the enlisted men to the chief of the dental service and at the same time transmits to the chief of dental service a copy of dental consultation request in duplicate as prescribed in *b* above.

194. Emergency officer.—A dental officer is detailed by roster by the chief of the dental service for the purpose of examining patients referred to the dental service for examination, for the treatment of emergencies, and for the survey of enlisted men of the command as required by Army Regulations. His tour of duty is for 24 hours commencing at 9:00 AM. During his tour of duty he keeps the information office constantly informed where he can be reached by telephone.

195. Appointments.—The chief of the dental service notifies the ward officer when patients in hospitals are given dental appointments. Ward officers are responsible that patients under their charge for whom dental appointments are made are required to report to the dental clinic promptly at the designated hour, or if such patient is unable to keep the appointment, are responsible that the chief of the dental service is so notified in advance.

196. Special cases.—*a.* Patients with suspected fracture of the jaw are referred to the dental service immediately upon admission. In the event the patient is admitted at other than duty hours, the dental emergency officer is notified.

b. When a patient is admitted to the ward for dental treatment only, the ward officer immediately notifies the chief of the dental service who expedites treatment with a view to his early discharge.

197. Responsibility for dental patients in hospital.—The ward officer of the ward to which a patient in hospital for "dental treatment only" has been assigned is responsible for the discipline, care, etc., of the patient, and for the preparation and maintenance of the patient's clinical record.

198. Reports.—*a.* The chief of the dental service advises the ward office 1 day in advance of completion of treatment of a patient in hospital for dental treatment only in order that the ward officer may take the necessary steps for discharge of the patient from hospital.

b. Upon completion of treatment in each case the chief of the dental service furnishes the ward officer with a copy of the patient's dental record on which is entered a summary of dental treatment given. This dental record is attached to and becomes a part of the patient's clinical record.

c. Immediately following the treatment for the eradication of dental foci of infection, the chief of the dental service forwards a report to the ward officer concerned on W. D., M. D. Form No. 55F, giving the dental diagnosis and treatment.

SECTION VIII

ARMY NURSE CORPS AND NURSING SERVICE

199. Status.—Relative to medical and sanitary matters and work in connection with the sick, members of the Army Nurse Corps and other nurses employed are to be regarded as having authority in and about military hospitals next after the officers of the Medical Department, and are at all times to be obeyed accordingly and to receive the respect due to their position.

200. Arrival procedure.—Upon arrival at the hospital, all nurses report immediately to the principal chief nurse for instructions and assignment to duty.

201. Principal chief nurse.—The principal chief nurse has supervision over all members of the Army Nurse Corps and the nursing service of the hospital. She is obeyed and respected accordingly. She has charge of the instruction, assignment, discipline, performance of duty, and conduct while on duty of members of the Army Nurse Corps. She has charge of the assignment, performance of duty, and conduct of female help employed for housekeeping purposes. She is responsible for—

a. Requisition, preservation, and disposition of equipment and public property for the nurses' quarters.

b. Sanitation and police in nurses' quarters.

c. Preparation and disposition of the records of her department.

d. Such other duties as are assigned her by Army Regulations.

202. Hours of duty.—The hours of duty for all members of the Army Nurse Corps and other nurses employed are as prescribed by the principal chief nurse.

203. Nursing service, personnel duties, and reports.—*a. Supervisors.*—(1) *General duties.*—Qualified members of the Army Nurse Corps are detailed when necessary as assistants to the principal chief nurse to supervise the nursing service of the hospital during the day or night tours of duty. Hours of duty are as prescribed by the principal chief nurse.

(2) *Day.*—The day supervisors perform such duties as may be required of them by the principal chief nurse.

(3) *Night.*—The senior night supervisor is responsible for the nursing service during her period of duty. Nurses apply to the night supervisor for instruction when necessary, and inform her as soon as practicable of any emergencies arising in their respective wards. Upon being relieved from duty in the morning she makes a written report of any unusual incidents of the night, and derelictions of duty on the part of the night nurses.

b. Head nurse.—The head nurse of the ward serves as its responsible nursing head. Under the direction of the ward officer she has charge of the ward, patients, nurses, enlisted personnel, and other persons assisting in the nursing care of the sick, and is obeyed and respected accordingly. Her hours of duty are the same as those of the other nurses, but ordinarily she is required to perform night duty only 1 month in 6. The head nurse sends the report of the nurses' time on duty to the principal chief nurse daily not later than 7:30 AM on the form provided for the purpose. She reports to the principal chief nurse concerning the efficiency of the nurses under her. She is responsible for—

(1) Receiving and recording of all orders relating to the care and treatment of patients in her ward.

(2) Proper administration of all medicines and treatments.

(3) Procurement of and proper serving of all foods in the wards to which no dietitians are assigned for duty.

(4) Careful, accurate, and legible preparation of all ward records and routine reports as required. In this connection, particular care is taken in maintaining the ward narcotic register.

(5) Safeguarding of keys of ward cabinets containing liquor, opiates, and poisons.

(6) Checking and care of the ward property, and preparation of the requisitions for needed supplies for the consideration and signature of the ward officer.

(7) Cleanliness and order of the ward and its adjoining rooms.

(8) Care of patients' effects, other than money and valuables, until transferred to the proper custodian.

c. Nurses.—Nurses perform such duties as may be required of them by the head nurses of their respective wards under the direction of the ward officer. They make a report of the work of their ward to the principal chief nurse at 7:00 AM and 6:00 PM daily on the form provided for the purpose. In order to minimize the number of night calls of the professional officer of the day, night nurses make every effort to obtain full instructions from him in regard to such matters as may be necessary when he makes his evening rounds, or before 10:00 PM if possible.

204. Relief procedure.—*a. Person in charge of ward.*—Nurses relieving others in charge of wards accomplish and sign the statement on the back of the Ward Morning Report showing the date and time they assumed charge and the number of patients to be accounted for as shown by the ward records. In closed wards, an actual physical count of all patients is made before the statement referred to is accomplished. In other wards of the hospital a similar check is made upon relief of person in charge between the hours of 6:30 PM and 9:00 AM only. Steps are taken to account satisfactorily for absentees from check, and when they cannot be properly accounted for report is furnished the ward officer, or in his absence the administrative officer of the day.

b. From duty.—On departure from hospital, either by transfer or on leave, all nurses report to the principal chief nurse's office for a clearance slip which must be completed as directed and returned to the principal chief nurse before departure. The address of all nurses going on leave must also be furnished the principal chief nurse.

SECTION IX

DISPENSARY

205. Function.—The dispensary functions as a station dispensary for the command.

206. Officer in charge.—The senior medical officer assigned to duty in the dispensary is in charge thereof and is known as the officer in charge of the dispensary. He maintains general supervision over all activities of the dispensary and is directly responsible for its efficiency. He assigns to their specific duties the personnel allotted to his sections and holds them responsible for their proper performance.

207. Medical attendance.—*a.* During hours other than those prescribed for the dispensary and in his absence, the duties of the officer in charge pertaining to medical attendance for persons applying at the dispensary are assumed by the medical officer of the day.

b. The officer in charge of the dispensary arranges that medical attendance is available for authorized persons calling during the prescribed hours.

c. The officer in charge of the dispensary is authorized to refer out-patients to the various professional services and sections of the hospital for examination and treatment.

d. No professional service or section of the hospital treats out-patients other than those properly referred thereto by the officer in charge of the dispensary.

e. Medical attendance is confined to members of the command authorized thereto by regulations, except that any emergency case brought to the dispensary is properly attended and disposition made as indicated. Only in emergency are persons not entitled to admission to Army hospitals admitted to hospital.

f. The officer in charge is responsible that the emergency dressing room is properly equipped and in readiness at all times for the reception and care of emergency cases.

208. Records.—*a.* The officer in charge of the dispensary maintains an out-patient index as prescribed in AR 40-1025 and FM 8-45, and is responsible for the proper indexing of the names and recording of all pertinent data concerning all persons treated.

b. Patients referred by him to other professional services or sections are accompanied by a request for consultation or treatment on the consultation request form. The officer examining the patient or giving the treatment notes on the form his opinion of the case and treatment given, returning the form to the officer in charge of the dispensary, who properly records the matter thereon.

c. On the last day of each month the officer in charge of the dispensary submits a report to the commanding officer containing the following information:

(1) Number of patients treated (by classes).
(2) Number of treatments (by classes).
(3) Number of physical examinations conducted (by classes).
(4) Number of persons carried in quarters (by classes).
(5) Summary of work, to include number of office visits, quarters visits, etc.
(6) Number and type of emergency cases treated.

d. A book is provided and kept in the emergency dressing room in which the officer treating an emergency case records all appropriate data relating to each case treated. As this book in many cases is referred to later for data required in the settlement of claims relating to the patient, every effort should be made to obtain a complete report of the patient's name, names of witnesses, circumstances, extent of injury, treatment given, and the name of the officer or officers giving the treatment.

209. Special duties of officer in charge.—In addition to his duties incident to the operation of the dispensary, the officer in charge—

a. Provides medical attendance for officers, nurses, enlisted men, and others quartered at station.

b. Holds sick call daily at a designated hour for enlisted personnel on duty at station.

c. Makes physical examinations of persons referred to him by proper authority.

d. Makes physical inspection (AR 615–250) of enlisted personnel on duty at station, reporting the result to the commanding officer giving the date on which held, the number of men inspected, the names of absentees, if any, the number of venereal cases found, the disposition of such cases, together with any other information of which the commanding officer should be cognizant.

e. Furnishes medical attendance to all patients marked "quarters" from hospital. He records in their clinical records the treatment prescribed, the progress of the case, and such other data as should be of record. He maintains a list of such patients, together with their home addresses, and requires them to report daily to the dispensary, except in the case of officers from the command on a quarters status, whose condition is such as to make a visit to the dispensary inadvisable.

f. Administers to such persons as may be entitled thereto such prophylactic, vaccination, and immunization for the prevention of communicable diseases as may be authorized.

SECTION X

PHARMACY

210. Operation.—The management and operation of the pharmacy is in conformity with paragraph 18, AR 40–590, and all personnel assigned to the department will acquaint themselves with the provisions of this paragraph.

211. Officer in charge.—A medical officer is detailed as officer in charge of the pharmacy. He maintains personal supervision over the pharmacy and is directly responsible for its efficiency. He causes the necessary records to be maintained in the case of alcoholic liquors and narcotics, and makes the necessary checks and verifications required by existing regulations (AR 40–590).

212. Noncommissioned officer in charge.—A qualified noncommissioned officer of the medical detachment is assigned in immediate charge of the pharmacy and is directly responsible to the officer in charge for its proper operation. He is furnished such assistants from the medical detachment as may be necessary. The noncommissioned officer in charge of the pharmacy is responsible that the prescriptions are compounded in accordance with the U. S. Pharmacopea, Dispensatory, and the National Formulary; that due care is taken in compounding; that prescriptions in which the prescribed dose exceeds physiological limits are not issued without verification by the prescriber; that prescriptions are properly filled and labels are prepared in conformity with paragraphs 214 and 215.

213. Emergency detail.—The officer in charge of the pharmacy details daily from the personnel allotted him a competent attendant for emergency duty during the period the pharmacy is closed. The name of the attendant so detailed is furnished the information office daily. The attendant so detailed does not leave the hospital area during his tour of duty and keeps the noncommissioned officer in charge of the information office constantly informed of his whereabouts.

214. Prescriptions.—*a. Notations.*—All prescriptions are written in the metric system and signed by a medical officer, except those

signed by officers of the dental and veterinary services for dental or veterinary patients, respectively, which are filled without reference to a medical officer. The noncommissioned officer in charge files all prescriptions as prescribed in existing regulations (AR 40-590).

b. Compounding.—Before filling any prescription, the compounding pharmacist makes sure that—

(1) The prescription is properly dated; is written for a definite person, ward, or clinic; it bears the patient's name and ward number or name of clinic or designation of ward.

(2) It contains directions for use unless it calls for original and unbroken package of a drug, or a drug which constitutes part of the stock in the ward medicine cabinets.

(3) The wording of the prescription is clear and unmistakable and that the dose of the active drug is not excessive.

(4) The prescription is signed by a medical officer or an officer of the Dental or Veterinary Corps for medical supplies needed in their respective services.

215. Label preparation.—Before issuing a compound prescription, the compounder assures himself that the label shows—

a. Serial number of the prescription and the date compounded.

b. Name of the person, ward, or clinic for which intended.

c. Directions as written on the prescription, or in the event that no directions are written, the contents of the container, the name of the officer who wrote the prescription, and the initials of the pharmacist who filled the prescription.

d. That all poisons as defined by paragraph 18*a*(3), AR 40-590, are properly labeled with a poison label.

216. Authority for dispensing medicine.—Except in cases of emergency, no drug or medicine of any kind is dispensed from the pharmacy except on a prescription signed by an officer of the Medical Corps, the Dental Corps, or the Veterinary Corps. No prescription is refilled except on a written prescription calling for such refilling, the prescription number being given.

SECTION XI

PROFESSIONAL OFFICERS OF THE DAY

217. Detail.—Two officers of the Medical Corps, in addition to other duties, are detailed as medical officer of the day and surgical officer of the day. A roster for this purpose is kept by the adjutant, and officers subject to detail are formally notified 24 hours in advance. The interchange of tours of duty as officers of the day, wholly or in part, is prohibited, except by permission of the commanding officer or his representative.

218. Tour of duty.—*a. General.*—The tour of duty for the medical officers of the day begins at 9:00 AM and continues for 24 hours. During this period the officers of the day remain within the limits of the hospital reservation. They keep the information office informed of their whereabouts at all times during their tours of duty. They sleep in the rooms provided for this purpose. During tour of duty officers of the day wear the prescribed brassard on the left arm.

b. Commencement and completion.—The tour of duty of the officers of the day automatically begins at 9:00 AM of the day they are detailed for such duty and automatically ends at 9:00 AM the following day. The new and old officers of the day do not formally report at the commencement or completion of a tour.

219. Duties.—*a.* The officers of the day are charged with the proper care of all patients in hospital assigned to their respective services during the absence of the ward officer and will be available for professional advice and service at all times during their tour of duty.

b. During the absence of the receiving and disposition officer, the medical officer of the day examines each patient on admission, makes the proper ward assignment, and prescribes such treatment as is indicated until the proper ward officer or the surgical officer of the day has assumed charge of the case.

c. The medical officer of the day assumes all duties of the receiving and disposition officer and those of the officer in charge of the dispensary during their absence.

d. The medical officer of the day notifies the surgical officer of the day upon the admission to hospital of a patient assigned to a surgical ward.

e. They make at least two complete inspections of their services during their tour of duty, one between 8:00 PM and midnight, and one between midnight and reveille. On each inspection they visit each ward, see all seriously ill patients, and ascertain that the hospital rules as to conduct are being observed and that the ward personnel are on duty and properly performing their duties. During the inspection they note the condition of the wards in regard to police

and sanitation and correct any violation of hospital regulations noted.

f. They answer all emergency calls promptly and if there is any doubt as to proper procedure they consult with the chief of the service or his assistant.

g. During the absence of ward officers, they determine all cases of death occurring on the service during their tour of duty, and see that the body is tagged with the name and other identifying data; that remains are properly prepared and promptly removed to the morgue; and that notice of death is prepared and transmitted as prescribed. They make an immediate search of the deceased person's bed, bedside table, and of the ward for clothing, money, valuables, or other effects belonging to the patient (see par. 89).

h. They take such other steps as they may consider necessary to assure the proper care and treatment of patients of the service during the absence of ward officers.

220. Record of tour.—The officers of the day upon completion of their tour of duty record in a book provided for the purpose in the office of the chief of the service the following:

a. Deaths and attending circumstances.

b. Serious cases attended and treatment administered.

c. Calls received from wards, noting the name of patient attended, the ward and treatment prescribed.

d. Names of patients and designation of wards of all seriously ill cases admitted to the service during his tour of duty.

e. Any matter he considers of interest to the chief of service.

221. Special instructions.—The chiefs of service instruct the officers of the day as to the patients in the service who, in their opinion, will require special attention during the absence of the ward officer.

222. Administrative officer of the day (attention of, assistance to).—The officers of the day report to the administrative officer of the day any violation of the hospital regulations noted, together with the action taken by them. In case of emergency, when the administrative officer of the day is already occupied or in need of assistance, the officers of the day are notified and take such action to assist the administrative officer of the day as may be necessary.

223. Alternate officers of the day.—Two officers of the Medical Corps are detailed as alternate officers of the day. The officers so detailed ordinarily are the officers detailed as officers of the day for the day following. They keep themselves available for duty as officers of the day in emergency.

CHAPTER 4

PROFESSIONAL STANDING ORDERS

SECTION I

GENERAL

224. General.—The compilation of professional standing orders is intended as a reference and guide to acceptable practices. It is not complete for all known methods of treatment nor is it intended that the compilation be restrictive to the medical or nursing staff of either a general or station hospital in the performance of their duties. Modification of any or all of the standing orders should be made by the medical or surgical staff as new methods or practices of proven value become available.

SECTION II

MEDICAL SERVICE

225. Clinical records.—*a. General.*—The clinical history and the physical examination of the patient are the basis for the institution of proper diagnosis and treatment and hence must be carefully made and

recorded. Hasty, more or less superficial history taking, often results in failure of diagnosis. The use of such words as negative are avoided, and the actual findings after thorough examination are carefully recorded.

b. Purpose.—History-taking affords the opportunity to obtain first-hand information as to the manifestations of diseases and their clinical causes. Furthermore, it is one of the most important fundamentals of diagnostic procedure. A careful correlation of the symptomatology and the physical and laboratory findings should lead to fairly accurate conclusions as to the proper diagnosis, a clear conception of which is necessary for the intelligent treatment of the abnormal condition or diseases.

226. Outline of history-taking.—Except in the family history and previous medical history, avoid the use of diagnostic terms throughout the history and physical examination.

a. Family.—Health, causes of death, ages of blood relatives, including husband or wife. Ascertain full details and especially inquire as to nervous and metabolic disorders, ductless glands, blood diseases, tuberculosis, cancer, etc.

b. Social.—Occupations and habits, home and working environment, kind and quantity of food, regularity of meals, mastication, alcoholics, substitutes, drugs, tea, coffee, tobacco, note regarding their consumption, and make definite statements as to amounts used. Investigation of sexual, marital, and social relationship when indicated.

c. Previous medical.—Condition from infancy in chronological order. Inquire as to scarlet fever, measles, whooping cough, typhoid fever, malaria (caution), sepsis, erysipelas, diphtheria, sore throats, chorea, rheumatism (inflammatory), influenza, heart disease, pleurisy, pneumonia, gout, lead poisoning, exposure to epidemics. In the history of any diseases obtained, note duration, complications, and sequelae, that is, in scarlet fever, ear trouble, and nephritis; in inflammatory rheumatism, condition of joints and injuries, when and cause. In women, note the number of pregnancies, abortions, and miscarriages induced or accidental. Note symptoms which are considered not connected with present illness, classified under the parts of the body. *Always obtain full information concerning* all positive symptoms. For convenience of those who wish to refer to one part of this section, symptoms should be listed in anatomical order, beginning with general symptoms and following with the various symptoms from the head to the extremities. Obtain full information about previous operations.

(1) *General symptoms.*—Weakness, alterations of weight, chills, fever, thirst, night sweats.

(2) *Head.*—Headache, vertigo, sleep, faintness.

(3) *Eyes.*—Lacrimation, photophobia, pain, vision, glasses.

(4) *Nose.*—Nasal or post nasal secretions, epistaxis, symptoms of obstruction.

(5) *Mouth, teeth, gums.*—History of previous illnesses affecting the oral mucosa; history of excessive caries, of sore and bleeding gums, of ill-fitting crowns or bridges; care given the teeth.

(6) *Throat.*—Frequent sore throats, hoarseness.

(7) *Lungs.*—Dyspnea, cough, expectoration, pain in chest, source of sputum, hemoptysis.

(8) *Heart.*—Palpitation, pain, dyspnea, and oedema.

(9) *G. I. tract.*—State of appetite, nausea, vomiting, frequency and character of bowel movements, relation of pain to food intake and bowel movements, hematemesis, melena, hemorrhoids (make inquiry concerning).

(10) *G. U. tract.*—Urination, frequency, amount, pain, nocturia, urgency, urethral discharge, genital lesions.

(11) *Menses.*—Frequency, character, duration, date of last period, vaginal discharge in intermenstrual period.

(12) *Extremities.*—Sensations in bones, joints, etc., oedema.

d. Chief complaint.—Get brief statement of dominant symptoms in the patient's own words. Avoid general expressions such as "stomach trouble," "heart trouble," etc.

e. Present illness.—(1) Begin with the earliest symptoms which can be connected with the present illness; for example, if patient complains of dyspnea and oedema of a month's duration which is considered to come from rheumatic heart disease, commence history with his attack of rheumatic fever 15 years ago. Put all symptoms in chronological order; for example, do not trace one symptom up to the present, then return to another. Indicate date of onset (not day of week); probable causes in opinion of patient, relatives, etc.; for example, trauma, "cold," mental or physical overwork, mental shock, exposure to infection and unusual hygienic conditions. Note mode of onset; for example, whether sudden or gradual. First symptoms; for example, weakness, chills, fever, pain (location and character), symptoms in stomach or bowels such as vomiting or diarrhea. Later course, try to have patient describe his case in chronological order and in his own way, but seek accuracy and fullness. Indicate in addition modifications in the course of the disease as influenced by treatment or otherwise. If medicines have been given or special inves-

tigations made, attempt to identify them as they may be an element in the present condition or indicate the diagnosis of previous physicians.

(2) After the symptoms have been described up to the time of admission, include a negative statement with regard to other symptoms which often accompany the disease which it is considered the patient has; for example, if the symptoms point to tuberculosis add, "No night sweats" or "hemoptysis," etc.; if of tabes, "No chancre, eruption, exposure," etc. In gastric histories be sure to include a complete description of dietary habits; in asthmatic inquire carefully into exposure to new or unusual proteins, animals of all sorts, feathers and mattresses, new geographical locations, etc.

227. Physical examination.—A careful physical examination presupposes that the patient is stripped, as abnormalities of structure or of function are often overlooked if this is not carried out. Due consideration should always be given to privacy and the feelings of the patient when this is done. Give particular attention to the part of the body suggested by the chief complaint. Do not devote too much space to the body in general.

a. Temperature, pulse, respiration (TPR), blood pressure.

b. Body in general.—Habitus; height, frame; small, medium, or large, slender or heavy; symmetrical or not with details in latter case.

c. Panniculus.—Muscular, lymph glands, vertebrae, ribs, long bones, joints, feet (flat or not); gait, station, tendon reflexes, tremors. General appearances; expression, mental condition, orientation, speech, memory, attention.

d. Skin.—Color of face, body, extremities, and visible mucous membrane, presence of cyanosis, icterus; warmth or coldness of skin, dryness or moisture, elastic or inelastic; oedema; eruptions, ulcers; striae; scars, subcutaneous nodules; hair on head and other parts; nails.

e. Head.—Shape of skull.

f. Eyes.—Reaction of pupils to light and in accommodation, equality; extra ocular movements; sclerae; intra-ocular tension; exophthalmos.

g. Ears.—Discharge, condition of external canal and tympanum. panum.

h. Nose.—Discharge, accessory sinuses, tenderness.

i. Mouth.—Condition of oral mucosa.

j. Teeth.—Unserviceable or irritating dental prostheses, oral disturbances due to dentition; peridontoclasia, suppurative; tophi; other clinical evidence of dental infection or of oral disease.

k. Tongue.—Soft palate and gums; bleeding, pallor, injection, coating, state of moisture.

l. Tonsils.—Buried, exudate, size, atrophied, hypertrophied.

m. Pharynx.—Adenoid tissue, lingual tonsil.

n. Neck.—Shape, size, pulsation of vessels, tumors, cysts, fistulae, scars (origin), larynx. Size, palpability, and visibility of thyroid.

o. Thorax.—Shape, size, type of respiration. Diaphragmatic phenomena, lagging, retractions. Note observation on palpation, percussion, and auscultation of lungs.

p. Heart.—Inspection; position and character of the cardiac impulse, palpation, thrills. Note findings on percussion and auscultation. Indicate rhythm, character of sounds; character, time in the cardiac cycle, and transmission of murmurs. Radial pulse, palpation of vessel wall, rate (increase on sitting up). Note other vascular phenomena such as pulsation in other arteries, veins, epigastrium, liver, capillaries.

q. Abdomen.—Form, size, floating tenth rib, visible peristalsis, masses (change position). Auscultation for peristaltic sounds and succussion splash. Note findings in the gall bladder region, liver, spleen and kidneys, urinary bladder, pylorus, appendiceal region. Determine presence and position of hernial sites. Examine all scars for firmness, hernia, etc.

r. Perineum.—Hemorrhoids, prostate. Character of seminal vesicles, hydrocele, induration, testes or cords.

s. Nervous system.—If a neurological syndrome is present, make a complete record of neurological examination.

228. Diagnosis impression.—Upon the completion of the history and physical examination the *impression* gained from such examinations is recorded on W. D., M. D. Form No. 55F. This serves as a tenative diagnosis until changed or modified by the ward officer.

229. Routine procedure on admission.—Routine procedure on admission for medical cases is as prescribed by the chief of section.

230. Diagnostic procedure.—*a. Basal metabolism test.*—(1) Age, height, and weight without clothing is obtained by charge nurse the evening before test.

(2) Temperature, pulse, and respiration taken by nurse at 8:00 PM and 6:00 AM.

(3) Patient in bed by 8:00 PM the night before test is made.

(4) Bathroom privilege may be granted up to 7:00 AM. Patient remains quietly in bed after midnight and until test is made which will be about 7:30 or 8:00 AM.

(5) No smoking after midnight.

(6) Breakfast is served to patient after test has been made.

(7) These instructions are given to patient the evening before the test.

b. Blood chemistry test.—(1) No breakfast is given ambulatory or bed patients until after blood has been taken. No food or liquids after midnight.

(2) Ambulatory patients report to laboratory at 7:00 AM.

(3) Bed patients and all female patients have blood taken in their rooms by the laboratory technician or by the ward officer when necessary. To avoid multiple punctures, blood for serological examination, chemistry and culture, if indicated, should be taken at the same time.

c. Gastric analysis.—Instructions to—

(1) *Patients.*—(*a*) Nothing by mouth after midnight before the test in the morning.

(*b*) No smoking from 7:00 PM, night before until after test is made.

(*c*) Report to gastric analysis room at 7:00 AM.

(2) *Nurse.*—(*a*) Have patient swallow tube.

(*b*) Remove fasting contents of stomach and enter quantity on slip.

(*c*) Give three arrowroot cookies with 400 cc. water.

(*d*) Withdraw specimens every 15 minutes until six specimens besides fasting specimen are obtained.

(*e*) If test is negative for free acid in all specimens and it is considered advisable to check the results with histamine; another request is submitted for that purpose.

(*f*) When histamine is given, the fact is noted on the laboratory request form.

(*g*) All tubes are labeled with patient's name and numbered in the order taken before being sent to the laboratory for titration.

d. Gastric fractional analysis with histamine.—(1) Give same instructions to patient as in *c*(1) above.

(2) Ward officer requesting fractional analysis with histamine notes the fact on the request. It is important that there is no contra-indication to the use of the drug and this is a responsibility of the patient's ward officer.

(3) Instructions to nurse are—

(*a*) Take fasting specimen, label and record on fractional slip.

(*b*) Take blood pressure and record.

(*c*) Give 0.5 mg. ergamine acid phosphate intramuscularly.

(*d*) Take subsequent specimens every 15 minutes until six specimens are taken.

(*e*) Take blood pressure 30 minutes after histamine is given and record.

(*f*) Look for local reaction at site of injection and if present also record.

(*g*) Patient must lie in bed while test is being done.

e. Proctoscopic examination.—(1) Contact chief of section and patient is given appointment.

(2) Patient continues usual diet. No laxatives are given.

(3) At 7:00 AM, day of examination, give two small (pt.) warm water or saline enemas in recumbent position. In selected cases a quart of 1 or 2 percent S. S. enema may be given (see par. 231*o* for preparation of enemata).

(4) On the day of examination have patient report to chief of section at 9:30 AM.

f. Glucose tolerance test.—Use micro method for children and elderly people.

(1) Nothing to eat or drink from midnight until after test is completed.

(2) Patient reports at laboratory at 7:00 AM, taking two lemons with him. Amount of sugar given computed by ward officer (usually 1.5 grams per kilo body weight). Blood specimens taken fasting and at ½-hour, 1-hour, 2-hour, and 3-hour periods.

g. Urine concentration test.—(1) At 5:00 PM the patient is given usual supper. If on a low protein diet, two poached or soft-boiled eggs are added to the meal. *This meal is to include no more than 200 cc. of fluid.*

(2) After eating supper no food or drink allowed until completion of test at 10:00 AM on following day.

(3) At bedtime patient instructed to empty the bladder and discard the urine. Any urine passed during the night is also discarded.

(4) At 7:00 AM the following morning the patient empties the bladder, saving the entire specimen in one bottle marked No. 1.

(5) At 8:00 AM patient again empties the bladder, saving the entire specimen in bottle No. 2.

(6) At 9:00 AM patient again empties the bladder, saving the entire specimen in bottle No. 3.

(7) The three bottles properly labeled with the name of the patient are then sent to the laboratory for taking specific gravity, or this may be done in the ward if responsible assistant is available to do so.

h. Urine dilution test.—(1) For supper night before the test the diet to which patient is accustomed.

(2) No breakfast the morning of the test.

(3) At 8:00 AM the patient empties bladder, discarding the urine; then give 1,000 cc. water to drink within 10 minutes (four glasses).

(4) Remain at rest for 4 hours and urinate in properly labeled bottle, emptying bladder each time and saving the entire specimen in proper bottle. Bottle No. 1 at 9:00 AM; bottle No. 2 at 9:30 AM; bottle No. 3 at 10:00 AM; bottle No. 4 at 10:30 AM; bottle No. 5 at 11:00 AM; bottle No. 6 at 12:00 noon.

(5) Amount in each bottle and the specific gravity of each specimen is then measured and recorded.

i. Encephalography.—(1) *Preparation of patient.*—(*a*) Remains in bed from the evening before the test.

(*b*) S. S. enema given the night before the test.

(*c*) Luminal 0.065 gram (1 gr.) or sodium amytal 0.195 gram (3 gr.) by mouth the night before the test.

(*d*) In event an additional use of an avertin anesthesia is advisable, the preparation of patient and administration of avertin is made under the direction and supervision of the surgical service.

(2) *Equipment.*—(*a*) Sterile spinal puncture tray. In addition, have at hand a spinal pressure manometer and on the tray a sterile 10-cc. Luer syringe.

(*b*) At hand have one hypodermic of caffeine-sodium-benzoate 0.487 gram (7½ gr.) and a second hypodermic of 1 cc. (15 minims) of 1 to $\frac{1}{1000}$ solution of adrenalin.

(3) *Personnel.*—(*a*) One medical officer.

(*b*) One nurse.

(*c*) Two assistants. The nurse assists the operator and also keeps an accurate written record of the actual number of cc. of spinal fluid withdrawn and number of cc. of air injected. The two attendants are needed to support and care for the patient under the direction of the operator.

(4) *Performance of test.*—Done at X-ray section to avoid moving patient any more than necessary before taking X-rays.

(*a*) Spinal puncture made with a narrow gage platinum iridium spinal puncture needle under the usual aseptic precautions, with the patient in the sitting position.

(*b*) Queckenstedt's test made.

(*c*) 15 cc. spinal fluid withdrawn.

(*d*) 10 cc. air injected with Luer syringe.

(*e*) Alternately withdraw 10 cc. spinal fluid and inject 10 cc. air several times.

(*f*) Then continue process, withdrawing 5 cc. of spinal fluid and injecting 5 cc. air. At intervals during this process head is rotated slowly from side to side and forward and backward. Withdrawals and injections are continued until there is no further flow of fluid

or until very fine bubbles come from the needle. The needle is withdrawn and puncture wound closed with sterile dressing. Check of amounts injected and withdrawn must be accurately kept to be sure more air is not injected than fluid withdrawn.

(*g*) X-rays should include right and left lateral views and AP and PA views of skull. Patient is kept in an erect position at the X-ray clinic until first views are developed sufficiently to determine if they are satisfactory. Upon completion of X-rays patient is immediately returned to the ward, placed in a shock bed with the foot of the bed elevated. During the whole procedure patient should be kept carefully protected from chilliness.

(*h*) Bed patient for at least 72 hours.

(*i*) Regular sedation as indicated for 72 hours.

j. Phenolsulphonephthalein test.—(1) Void urine, then drink 3 glasses of water. 8:30 AM.

(2) Give exactly 1 cc. of dye by vein ½ hour later. 9:00 AM.

(3) 1 hour and 5 minutes after dye is given, void and save specimen in bottle marked 1st hour.

(4) 2 hours and 5 minutes after dye is given, void and save specimen in bottle marked 2d hour.

(5) Do not drink any water after beginning of test and do not void between specimens.

k. Throat culture.—(1) Obtain sterile swab in test tube and Loeffler's tube from laboratory if not found on ward.

(2) Inoculate swab thoroughly from tonsil fossae, posterior pharyngeal wall and uvula when indicated.

(3) Remove paraffin stopper from Loeffler's tube after heating gently.

(4) Gently inoculate Loeffler's slant without breaking its surface.

(5) Return swab to sterile tube, plugging same with sterile cotton plug.

(6) Write patient's name on label on Loeffler's tube and wrap both tubes in W. D., M. D. Form No. 55L, prepared in duplicate.

(7) Send immediately to laboratory, night or day.

l. Urea clearance test—(1) An ordinary breakfast is given except that the patient must not have coffee, tea, or citrus fruits.

(2) The patient remains quiet. At about 8:00 AM the patient empties bladder, discarding this specimen. Time of voiding noted by hour and minute. Patient drinks glass of water after urinating.

(3) Exactly 1 hour after first urination, patient again empties bladder, saving entire specimen. Time of voiding noted by hour and minute. Patient drinks glass of water after urinating.

(4) 5 cc. of blood taken from a vein into oxalate within 10 minutes before or after second urination mentioned in 3 above. Time of specimen noted by hour and minute.

(5) Exactly 1 hour after second urination patient again empties bladder, saving entire specimen. Time noted by hour and minute.

(6) Both of the urine specimens and the blood specimen are sent to the laboratory with a record showing the time each specimen was obtained.

(7) The clinical laboratory should be notified the day before the test is to be made.

m. Oral cholecystography.—See section VIII.

n. Biliary drainage (Meltzer-Lyon test).—(1) *Passage of tube to stomach.*—(*a*) Patient fasts 12 to 15 hours and reports for test at 7:00 AM without breakfast.

(*b*) Patient swallows tube to 22-inch mark.

(*c*) Aspirate stomach content and save in first tube for study of amount, color, gross consistency, microscopic and chemical findings (usually 15 to 40 cc.)

(2) *Passage of tube to the duodenum.*—(*a*) Patient lies down on a bed and turns well on his right side and swallows tube to the 29-inch mark very slowly.

(*b*) Insert end of Rehfuss tube in second test tube, keeping rack on chair below level of stomach and observe same from time to time until an alkaline fluid is obtained. Test by litmus paper. This fluid is duodenal content and should be saved in second tube for study of amount, color, microscopical examination, occult blood, pancreatic ferment determination, etc. *Usually 10 cc. or less.* If bile is obtained before magnesium sulphate is instilled the common duct spincter is open and part of the bile (A) has escaped and cannot be differentially estimated.

(3) *Drainage of bile.*—(*a*) Instill 75 cc. of 33 percent magnesium sulphate (body temperature) into duodenum slowly by gravity; pinch the tube to hold its syphonage and attach to drainage bottle or tube. May substitute 25 cc. concentrated magnesium SO_4 diluted to 75 cc. with water. The bile will flow out without aspirations.

(*b*) Collect the bile in separate containers as follows:

1. A.—Light golden yellow bile coming from the gall ducts. Save in tube 3 (common, cystic, hepatic) (usually 5 to 30 cc.).

2. B.—Dark golden yellow bile coming from the gall bladder. Save in tube 4 (usually 30 to 75 cc.).

3. C.—Light, thin, yellow bile coming from the liver (usually 30 cc. or more). Save in tube 5.

(*c*) If gastric juice gets into the bile the color may become greenish (oxidation to biliverdin), turbid, and sometimes effervescent due to action of HCL upon the salts.

(*d*) The total duration of the test will vary between 1 and 3 hours. If liver drainage is essential in treatment it may be continued for 6 hours.

(4) *Examination of bile.*—(*a*) Gross or microscopic examination. Make note of—

1. Amounts of A, B, and C bile.
2. Color.
3. Clear or turbid.
4. Presence or absence of white or bile stained flakes.
5. Precipitates (from admixture with gastric juice).
6. Viscosity (mucous).
7. Blood.

(*b*) Microscopic examination of fresh and stained smears (within hour of collection).

1. Epithelial cells (may be degenerated "shadow cells").
2. Leukocytes.
3. Mucous (long, waxy, curled strands).
4. Crystals (cholesterin, leucin, tyrosin, calcium bilirubin).
5. Pigments (bilirubin calcium: lustrous orange masses, sometimes like sand).
6. Bacteria.
7. Precipitates (gastric juice effect on bile salts: granules).
8. Parasites or ova (lamblia, chilomastix, ameba, hook worms, round worms, etc.).

(5) *Interpretation of results.*—(*a*) Failure to get tube into duodenum may be due to—

1. Pylorospasm.
2. Gastroptosis and gastric atony.
3. Organic disease of stomach and duodenum, extragastric tumors, etc.

(*b*) Chronic cholecystitis or biliary tract disease: pus and bacteria in the bile.

(*c*) Gall stones: a heavy pigment sediment or findings of crystals (cholesterin, calcium bilirubin).

(*d*) Gall bladder stasis: large amounts of deep colored viscid bile.

(*e*) Parasitosis: most parasites in B fraction if gall bladder is infected.

(*f*) Blockage of cystic duct: absence of B fraction.

o. Feces examination (warm specimen) for amebae.—(1) Careful attention must be given to the collection of the specimen of feces and delivery to the laboratory. In chronic cases in whom it may be difficult to get a satisfactory specimen give patient 45 cc. magnesium sulphate before breakfast. As soon as catharsis occurs have patient pass specimen in a bedpan previously made warm by hot water, take the feces to laboratory immediately, and bring same to attention of laboratory personnel as an emergency examination. Chronic dysentery cases usually receive four such tests before they are considered negative for ameba. In acute cases where no cathartic is needed, collect specimen with the same care above outlined.

(2) The laboratory report should show the character of the stool, the presence or absence of R. B. C., W. B. C., mucous, parasites and cysts.

Caution.—It is not sufficient to report on presence or absence of parasites only. It is very important to know if the stool is pale (lacking bile), or tarry (containing old blood), watery or scybalous, if gross exudate is present or not, etc.

231. Therapeutic procedure.—*a. Administration of intravenous hypertonic salt solution in thromboangiitis obliterans (in selected cases).*—(1) The quantity used is 300 cc. and the strength 3 to 5 percent.

(2) The solution warmed to body temperature is given by intravenous infusion, gravity method, requiring about 15 minutes to give the entire amount.

(3) A course of twelve of these injections may be given twice weekly, and repeated after an interval of 6 weeks. During this time a course of twelve injections of typhoid vaccine is given. (See *g* below.)

(4) During a course of treatment with hypertonic salt it is important to have occasional blood counts to avoid a secondary anemia.

(5) Patients should remain in bed for at least 4 hours after the injection, and should abstain from drinking water during this period.

b. Cold wet pack.—(1) One rubber sheet, four ordinary sheets, four blankets, one bath towel.

(2) Rubber sheet spread smoothly on bed.

(3) Ordinary sheets soaked in ice water, wrung out well, and spread smoothly on bed.

(4) Patient supine (on back) with arms raised above head.

(5) First sheet wrapped tightly about patient's body, legs, and feet.

(6) Patient's arms lowered to side.

(7) The remaining sheets one by one wrapped tightly about patient mummy fashion.

(8) Blankets one by one wrapped tightly about patient.

(9) Bath towel soaked in ice water, wrung out, and wrapped around patient's head, leaving mouth and nostrils clear.

(10) Push fluids while in pack.

(11) TPR q 30 minutes.

(12) Watch closely for sudden temperature rise.

(13) Leave in pack from 30 minutes to 1½ hours, depending upon sedative effect obtained and patient's reactions.

(14) Ordinarily packs may be given three or four times within 24 hours.

c. Malarial inoculation.—(1) Luer 10-cc. syringe.

(2) Large gage needles as required.

(3) Tourniquet, iodine, alcohol.

(4) Clean donor's arm with iodine and alcohol and apply tourniquet.

(5) Clean patient's arm and shoulder just below scapula with iodine and alcohol.

(6) Withdraw from 5 to 10 cc. donor's blood.

(7) Change needles on hypodermic and inject 3 cc. of blood intravenously into patient.

(8) Add 2 cc. of air to remaining blood, and inject blood and air intramuscularly under scapula.

(9) Massage gently to promote maceration and absorption of injected blood.

(10) The air is added to promote maceration and irritation.

(11) The incubation period of quartan malaria given by this method is from 1 week to 4 months.

(12) Blood can be treated as for indirect transfusion and if kept on ice will retain its malarial potency for 24 to 48 hours.

d. Postural drainage.—(1) The treatment is carried out by first placing the patient for 10 minutes on the healthy side to permit drainage of the purulent material into the larger bronchi and if the abscess is in the upper lobe, the patient should sit erect for 10 minutes before lying on the healthy side.

(2) Then the patient's trunk should be inverted by having him lie crosswise on the bed with the groins at the edge of the bed, so that the body is bent at the hips and the head is at or near the floor,

with the body vertical; an attendant should hold the thighs as they lie across the bed. The position is to be maintained from 3 minutes at first up to 5 minutes. A pus basin should be available, although coughing and expectoration are seldom promoted until patient is again back in bed.

(3) This procedure should be done four times a day, ½ hour before meals (because of possible emesis), and at bedtime.

e. Summation typhoid inoculation (for protein shock for whatever purpose).—(1) Fresh triple typhoid vaccine of 100 million bacteria per cc. made up in normal salt.

(2) Small gage needles as required, 10-cc. hypodermic, tourniquet, iodine, and alcohol.

(3) Dosage varies with patients and with each individual patient from time to time, so small dosage is indicated until patient's tolerance is learned.

(4) ¼ cc. of the vaccine dilution or 25 million typhoid bacteria, to which is added sterile salt solution qs. 5 cc.

(5) Inject slowly intravenously.

(6) TPR q 30 minutes. The strength of next dose depends on temperature reaction.

(7) Patient usually has chill, followed by rise in temperature in from 15 minutes to 2 hours.

(8) The next injection is given not sooner than 3 hours following first, and not at all if the fever following the first injection rises to 103° F.

(9) The second injection is usually followed by a sudden sharp rise of temperature.

(10) Push fluids during fever reaction.

(11) After temperature drops to 102° give codeine sulphate 0.032 for headache.

(12) Bed patient for 24 hours.

(13) Treatments can be given ordinarily twice weekly, gradually increased dosage being required.

(14) A temperature of at least 104° F. is desirable where this type of treatment is indicated.

f. Immediate treatment of hemorrhage from upper gastro-intestinal tract (for use when patient is admitted during the absence of ward officer).—(1) Patient must be seen by the medical officer of the day.

(2) Absolute bed rest.

(3) Emergency complete blood count.

(4) Blood pressure and pulse taken and recorded hourly.

(5) Morphine gram 0.016 (¼ gr.) (medical officer must see patient before this is given). Morphine may be repeated if necessary to get the patient quiet.

(6) Give nothing by mouth.

(7) Ice bag to abdomen.

(8) Minimum amount of physical examination will be done. Disturb patient as little as possible.

(9) All vomitus and feces specimens to be saved for inspection.

(10) If condition of patient appears alarming as evidenced by red cell count, hemoglobin, blood pressure, and pulse, have the patient typed and select a blood donor for transfusion. A small transfusion of 250 cc. whole blood is preferred.

g. Nonspecific protein therapy.—(1) A course of typhoid vaccine therapy consists of twelve intravenous injections, two injections being given each week. The course therefore requires six weeks. The dosage is as follows:

(*a*) A preliminary dose of 10 million bacilli is given intravenously as a test dose. If the patient proves not to be hypersensitive the following schedule is suggested:

Injection	*Million bacteria intravenously*
1	25
2	50
3	100
4	150
5	200
6	250
7	300
8	400
9	500
10	600
11	800
12	1,000

(*b*) The increase in dosage is approximate and may be more or less rapid, depending upon the individual reactions.

(2) A minimum temperature of 102° is desired in Buerger's disease and a maximum of 103°. In acute arthritis, however, higher temperatures are desired; a minimum of 103° in the nonspecific type and 104° to 105° in the gonococcic type. If the desired temperature is not obtained with the injection listed, the summation method is used. See *e* above.

(3) The typhoid vaccine now supplied by the Army Medical Center is the "triple typhoid vaccine." Each cubic centimeter of this vaccine contains—

(*a*) 1,000 million typhoid bacilli.

(*b*) 250 million para A bacilli.

(*c*) 250 million para B bacilli.

h. Treatment of pneumonia.—In regard to the following outline of treatment of pneumonia cases, it should always be borne in mind that it is the individual patient and not the disease that is under treatment; therefore, certain modifications in any plan of treatment are always permissible.

(1) *Routine procedure.*—(*a*) Upon admission, patient's history is taken briefly (including interrogation relative to previous allergic states: history of hay fever, asthma, sensitivity to horse dander, previous administration of serum and reactions), and such physical examination is made as the physical condition justifies.

(*b*) Absolute bed rest; possibly a private attendant.

(*c*) Complete blood count at once and daily until further orders.

(*d*) Test for serum sensitiveness as shown below if serum is to be used.

(*e*) Sputum to laboratory in sterile petri dish with form marked emergency for typing. For method of proper collection see paragraph 232*e*.

(*f*) Emergency bedside X-ray of chest.

(*g*) Give serum or sulfathiazole as indicated.

(*h*) Routine urinalysis, Kahn and other laboratory examinations as indicated.

(*i*) Have patient fed by attendant.

(*j*) Blood culture should be obtained on admission and then as indicated.

(*k*) Enema (plain water or saline) should be used daily if necessary. Prevent abdominal distention.

(*l*) Seriously ill notice is initiated, if indicated.

(*m*) Temperature, pulse, and respiration recorded on graphic chart every 4 hours. Blood pressure should also be recorded frequently, especially if serum is given.

(*n*) Keep windows open but protect from direct drafts by use of screens.

(*o*) Report to Board of Health.

(*p*) See that patient obtains sufficient sleep.

(*q*) Use liquid diet for first few days, small amounts at short intervals. No iced fluids as these tend to cause distention. Measure fluid intake and output. Intake should be 2,500 cc. to 3,000 cc. daily, depending on the urinary output. The urine output should be at least 800 cc. to 1,000 cc. in adults.

(*r*) Do not use digitalis or cardiac stimulants unless specifically indicated by falling blood pressure and increasing heart rate. Use oxygen early if indicated by some cyanosis and hyperpnea. When oxygen is used the procedure of its administration should be carefully controlled and supervised.

(2) *Serum therapy.*—(*a*) Serum is available for use in all types of pneumonia, but is most efficacious in types I, II, IV, V, VII, VIII, and XIV. Both horse serum and rabbit serum are obtainable for treatment. The technique of administering horse serum and rabbit serum is the same.

(*b*) Have hypodermic syringe prepared, and in the patient's room, of 1 cc. of epinephrine 1:1,000 for use in treating allergic reactions.

(*c*) The following sensitivity tests are to be performed prior to serum administration:

1. *Conjunctival test.*—For this purpose a drop of 1 to 10 dilution of normal horse serum is instilled into one conjunctival sac. A positive reaction appears within 15 minutes, manifesting itself by hyperemia of the conjunctiva, dilated conjunctival vessels, increased lachrymation, and sometimes itching. *A conjunctival reaction constitutes a definite contraindication to serum therapy.* If the conjunctival reaction is severe it may be neutralized by the instillation of epinephrine solution 1 to 1,000 in the conjunctival sac. Of the three reactions employed for sensitivity to horse serum the conjunctival is the most reliable in ruling out anaphylaxis, except perhaps in crying children when the drop of serum instilled in the conjunctival sac is likely to be washed out by the tears as soon as put in. (A small capillary tube with 1 to 10 horse serum is furnished with each package of antipneumococcic serum.) This test is not usually performed when administering rabbit serum, since the skin and intravenous tests are more reliable.
2. *Skin test.*—For this purpose 0.1 cc. each of 1 to 10 and 1 to 20 dilution of normal horse serum (controlled by 0.1 cc. of normal saline) is injected intradermally. The reaction is read in 30 minutes. If strongly positive, the benefit to be expected from serum must be weighed against the danger of serious reaction. If it is decided to give serum in the presence of a strong reaction it must be given with caution. If the case is urgent it may be given provided the patient is desensitized by the giving of serum in divided doses at 1-hour intervals, beginning with 0.1 cc. under the skin,

0.2 cc., 0.5 cc., and 1.0 cc. From this point, if no reaction occurs, the intravenous injections may be started in the same amounts as above, and after 1.0 cc. is given intravenously with no reaction, the amount is doubled at each injection until the full dose has been given. If a reaction occurs, half of the epinephrine 0.5 cc. (7.5 minims) is given subcutaneously, repeated in 10 to 15 minutes if necessary, and if the reaction is severe or if no relief is obtained with the epinephrine, morphine and atropine are given subcutaneously.

3. Intravenous test.—5 cc. of a 1 to 50 dilution of rabbit serum in normal saline is slowly injected intravenously. Check the blood pressure before the test and 5 minutes after the test. If the blood pressure falls 20 millimeters of mercury or more, serum is contraindicated.

(*d*) *Dosage of serum.*—If all tests are negative, give—

1. 10,000 units proper type antipneumococcus serum intravenously, undiluted and very slowly (at least 10 minutes), with 0.3 cc. (5 minims) of epinephrine solution (1 to 1,000) in the serum.

2. If no reaction in 2 hours, give 20,000 units of serum intravenously, slowly. Then repeat every 2 hours until total dosage is given.

3. The total dosage should vary from 60,000 to 200,000 units, depending upon the day of illness, extent of involvement, complications, progress of the case, age, and condition of the patient.

(*e*) Reactions encountered are of three types, anaphylactic, urticarial, and thermal.

1. Anaphylactic reactions are manifested by apprehension, tachycardia, choking sensation in chest, cyanosis or edema of the larynx. Death may follow in a few minutes. The treatment consists of the immediate administration of 0.5 cc. to 1.0 cc. (7.5 minims to 15 minims) of 1 to 1,000 epinephrine hydrochloride subcutaneously and/or 3 minims to 5 minims intravenously, to be repeated if necessary. Morphine and atropine should also be given if indicated.

2. Urticarial reactions are of two types, the immediate and the delayed. The former appears about 15 minutes after the serum administration and is manifested by flushing of the face, rapid pulse, apprehension, and an urticarial rash. The treatment is essentially the same as for the anaphylactic reaction. The delayed reaction or "serum sickness"

usually appears from 5 to 15 days after the administration of the serum. It is manifested by urticaria, intense itching of the skin, diarrhea, muscle and joint pains. The urticaria is best treated with epinephrine, potassium chloride, sodium bicarbonate, or calamine lotion applications, alcohol rubs, etc. The muscle and joint pains usually respond to salicylates and/or codeine. Morphine has to be given in some cases to control the intense itching, pain, etc. Catharsis as indicated.

3. Thermal reactions manifest themselves by chills and sudden elevation of temperature, usually 1 hour to 2 hours following the serum administration. The treatment consists in the application of external heat at time of chills. Morphine, 0.010 (1/6 gr.), and/or nitroglycerine, 0.00065 (1/100 gr.), may be indicated and beneficial for the apprehension and discomfort.

(3) *Chemotherapy.*—(*a*) For pneumococcic pneumonia give sulfathiazole after the above-enumerated routine procedures have been carried out. The following schedule is recommended:

1. For adults (patients over 14 years of age), give 4.0 grams stat., followed by 1.0 gram every 4 hours, day and night until the patient's temperature has been normal for 72 hours. Then discontinue the drug.

2. In children the initial dose should be based on 0.15 gram per kilo (up to 25 kilo body weight), and the total daily dose is calculated on that basis. The total daily dose after the initial dose should be divided into four equal parts, and one dose given every 6 hours until the temperature has been normal for 36 hours.

3. During drug therapy and for a few days thereafter:

(a) Daily complete blood count (watch for hemolytic anemia or agranulocytosis.)

(b) Blood for sulfathiazole content daily, or three times a week as indicated. Concentrations of 3 to 6 milligram percent of free drug are considered adequate in the average uncomplicated case.

(c) Sulfathiazole reactions may include nausea, vomiting, headache, rash, cyanosis, delirium, fever, hemolytic anemia, jaundice, and agranulocytosis. Patients should be carefully watched for such reactions so that appropriate treatment may be instituted promptly.

(*b*) Other sulfonamide compounds (sulfanilamide, sulfapyridine etc.) may be necessary in certain special cases and will be ordered as indicated. See circular letter No. 81, S. G. O., 1940.

(4) *Oxygen therapy.*—(*a*) Oxygen tents, tanks, analyzers, and equipment are ready for use at all times in a designated place. This office also provides a roster of properly qualified enlisted attendants who are available to set up and operate these tents whenever necessary.

(*b*) Oxygen makes breathing easier. It lowers the pulse and respiration and often lowers the temperature. It increases the arterial oxygen saturation and relieves cyanosis. It prolongs life, thereby affording the patient more time in which to build up his resistance to overcome the infection. The chief indication for oxygen in pneumonia is cyanosis. It has been found that slight cyanosis of fingertips and of lips corresponds to about 10 percent oxygen desaturation and that when cyanosis is marked the blood is more than 20 percent desaturated. The oxygen content of atmospheric air is 21 percent; in treating pneumonia with oxygen the aim is to increase the oxygen supply to 50 percent in the tent.

(*c*) All officers and nurses should be familiar with the operation of oxygen equipment and analyzers.

i. Treatment of diabetic coma.—The following procedures are offered as a guide in the treatment of diabetic coma. There is no definite rule for determining the amount of insulin or the amount of fluid necessary. Each patient will have to be considered as an individual problem.

(1) *Urinalysis.*—Examine a specimen of urine immediately for sugar, acetone, and diacetic acid. Catheterize if necessary.

(2) *Blood chemistry.*—Obtain blood for blood sugar, CO_2 combining power, and urea nitrogen.

(3) *Insulin.*—If definitely a case of diabetic coma, give an initial dose of 20 to 100 units (average, 40 units) of regular insulin. Occasionally it will be necessary to give a portion of the insulin dosage intravenously. Insulin should be given every 30 to 60 minutes until the patient shows some improvement. The results of urinalysis can be used as a guide for giving insulin, 5 units of insulin being given for every 1+ of glycosuria. The bladder should be completely emptied each time urine is obtained when giving insulin according to urinary findings. If there is no definite improvement in 3 hours, larger doses of insulin should be given. It is very essential to give an adequate amount of insulin and it is a good practice to give insulin buffered by glucose in saline, intravenously when there is marked acidosis. The amount of insulin required in 24 hours varies greatly.

It may vary from 50 to 1,000 units. The average amount necessary in 24 hours is 200 to 250 units. The danger of hypoglycemic reactions has been greatly overemphasized. Obtain blood sugars at intervals of 4 to 8 hours until the patient is out of coma. The micro method should be used for children and elderly people. *In view of the delayed reaction of protamine zinc insulin, only regular insulin should be used.*

(4) *Fluids.*—Normal saline solution should be given liberally. If the patient is badly dehydrated, 2,000 cc. to 3,000 cc. of saline should be given intravenously in the first 12 hours. The average requirement for all cases of diabetic coma varies between 2,000 cc. and 4,000 cc. in 24 hours. This saline can be given intravenously, subcutaneously, or by protoclysis. After the blood sugar has been lowered, glucose in saline can be given. The patient should receive approximately 50 grams of soluble carbohydrate (glucose, orange juice, sweetened drinks, etc.) buffered with insulin during the first 12 hours and a similar amount during the second 12 hours. After the patient is able, fluids by mouth can be given. This should be given at a rate not to exceed 100 cc. every hour. If the condition remains serious, the CO_2 combining power remaining low and the insulin medication seemingly ineffective, the use of 250 cc. of 5 percent solution of sodium bicarbonate intravenously is indicated.

(5) *General measures.*—Shock is combated by placing the patient in a warm bed and the use of blankets and hot water bottles. Gastric lavage is indicated in practically all cases, and 200 cc. to 300 cc. of 5 percent solution of sodium bicarbonate should be allowed to remain in the stomach. Initial treatment should also include catheterization and an enema.

(6) *Circulatory failure and anuria.*—Caffeine-sodium benzoate and digitalis by hypo can be used as circulatory stimulants. Hypertonic solutions of glucose (100 cc. of a 25-percent solution) or a 10-percent solution of sodium chloride (100 cc.) have been reported as being successful in combating anuria.

(7) *Diabetic coma is a medical emergency. The patient will remain under the observation of the responsible medical officer until danger of relapse into coma is past.*

j. Treatment of pulmonary hemorrhage.—(1) A patient with hemoptysis should be put to bed at absolute rest and should remain there for 5 days following the disappearance of blood from sputum.

(2) A patient with pulmonary hemorrhage should be immediately placed in bed, made comfortable and kept absolutely quiet, not even being allowed to talk. A supine position with head of bed elevated is preferable.

(3) He should be reassured as to condition as the avoidance of mental tension and emotion is an important factor in the treatment.

(4) He should be advised to avoid or control all unproductive cough. If excessive unproductive cough persists, 0.032 gram (½ gr.) doses of codeine dissolved on the back of the tongue may be used.

(5) Cracked ice may be given by mouth, but little fluid otherwise.

(6) Also a powder consisting of sodium bromide and sodium chloride, 0.975 gram (15 gr.) each. These remedies may be repeated in ½ hour, if indicated.

(7) Morphine should never be used in pulmonary hemorrhage save to quiet extreme excitement or to control cough which has failed to yield to other measures.

k. Treatment with tryparsamide.—(1) Recommendations for treatment with tryparsamide are made by the neuropsychiatric section of the medical service.

(2) Prior to treatment the patient is given a complete physical examination, to include blood and serology.

(3) Eye examination, to include fundus and visual fields is made prior to each and every treatment.

(4) The administration of tryparsamide is made by a commissioned officer from the G. U. section.

l. Treatment of Cerebrospinal meningitis.—(1) Test patient for sensitivity to serum, using skin and conjunctival tests (see *h*(2)(*c*) *1* and *2* above).

(2) Have two sterile culture tubes to send specimens of spinal fluid to laboratory.

(3) Make out requests for examination of spinal fluid.

(4) Prepare two hypodermics, one with 0.016 gram (¼ gr.) morphine and the other with 1 cc. 1 to 1,000 adrenalin.

(5) Use local anesthesia for spinal puncture, at least for the first.

(6) Do lumbar puncture. Send first few cc. to laboratory for smear, culture, cell count, and on first specimen, in addition, agglutination of organisms from culture against therapeutic sera.

(7) Read sensitization tests again before administering serum in the vein, if serum is to be used. (See circular letter No. 81, S. G. O., 1940.)

(8) Mix 100 cc. of serum with equal quantity of warm saline solution and inject slowly in vein by gravity. As the injection is started, give one-third of the adrenalin under the skin and save the rest for emergency.

(9) Special attendant remains with patient.

(10) Send in seriously ill notice.

(11) Report case to Board of Health.

(12) Routine laboratory procedures: white and differential count, urine and culture from nares and from throat for meningococcus.

(13) Sulfanilamide will be used, using essentially the same dosage and precautions as prescribed in other severe infectious conditions. (See circular letter No. 81, S. G. O., 1940.)

m. Treatment of status asthmaticus.—(1) Epinephrine 1 to 1,000 subcutaneously 0.3 to 1.0 cc. every hour until relief is apparent but not more than four such consecutive doses. May give 0.07 to 0.15 cc. intravenously diluted to 2 cc. with normal saline.

(2) Combinations of epinephrine (0.3 cc.) and pituitrin (0.5 cc.) or epinephrine (0.3 cc.) and aminophyllin (1 ampoule 0.5 gm.) intramuscularly.

(3) Adequate fluid intake, orally or intravenously; glucose 100 to 150 grams daily, orally, and 0.3 to 0.6 epinephrine, three or four times daily subcutaneously. Glucose 10 percent intravenously if necessary.

(4) Sedation. Barbiturates. Dilaudid 0.001 repeated once if necessary. Morphine 0.004, with caution.

(5) Avertin anesthesia, rectal 50 to 70 mgm per kilo body weight.

(6) Ether in olive oil, equal parts, by rectum 150 cc. to 200 cc.

(7) Sodium iodide intravenously 20 cc. ampoule (2 gr.).

(8) Digitalis leaves 0.100 gram to 0.200 gram orally in older asthmatics with rapid, feeble pulse.

(9) Caffeine sodium benzoate 0.5 gram subcutaneously or caffeine citrate 0.3 gram to 0.5 gram orally.

(10) Whisky, 60 cc. to 90 cc. several times daily.

(11) Continuous intravenous administration of 5-percent glucose with 1 to 200,000 epinephrin (constant drip method).

(12) Oxygen tent (or oxygen 20 percent and helium 80 percent, if latter is available).

(13) Cleansing enema, if necessary, with moderate food intake, relaxation and sleep, allergic cleanliness insofar as practicable.

n. Treatment with vitamin K.—(1) The method of administering vitamin K depends upon the degree of deficiency of this vitamin as measured by the prothrombin "time" (Quick, Smith or modified Howell method.) (Modification of Howell's method (American Journal of Medical Sciences, September, 1940).)

(2) Cases of obstructive jaundice, hepatitis, etc., which show normal values require only prophylactic treatment and may be given synthetic vitamin K and bile salts orally.

(3) Patients with definitely prolonged prothrombin time and those who are actively bleeding from the second and third classifications. The former may be started on oral therapy but if they fail to respond in a short time, must be given liquid concentrate of vitamin K and bile salts by means of the duodenal tube. The latter (actively bleeding cases) require the intravenous administration immediately, and may also require blood transfusions to tide them over the period of greatest danger. In the tube method, 2 to 4 grams of bile salts are dissolved in 250 to 500 cc. of warm saline solution and to this are added 0.3 to 2.00 grams of the concentrated vitamin K. The mixture is shaken frequently and allowed to flow slowly through the tube over a period of about 30 minutes. When such large doses are used, the prothrombin time usually becomes normal within 6 to 12 hours, but in an exceptional case it may be necessary to repeat the procedure one or more times before the hemorrhage can be controlled.

o. Enemata.—(1) *Types.*—(*a*) *Plain water.*—Warmed to body temperature (99° F.).

(*b*) *Saline.*—8 grams (2 level teaspoonfuls) of ordinary salt to 1 quart of warm water (99° F.).

(*c*) *Soap suds.*—1 percent to 2 percent solution of a white, bland, nonirritating soap; 1 teaspoonful of powdered soap in 1 quart of warm, water (99° F.).

(*d*) *Purgative or compound.*

1. Small evacuant enema.

Magnesium sulphate	60 gm.
Glycerine	30 cc.
Water	120 cc.

2. Large purgative enema.

Magnesium sulphate	60 gm.
Glycerine	60 cc.
Oil of turpentine	4 cc.
Hot soap suds (1 percent)	500 cc.

(2) *Methods of administration.*—(*a*) If the rectum only is to be emptied, 1 pint of the enema is injected rapidly with the patient in the sitting posture (for patients not too debilitated to sit up).

(*b*) For cleansing the entire bowel, 1 quart of the enema should be used with the patient recumbent or better still in the knee-chest position (if not too debilitated) and the solution given very slowly to prevent cramping.

232. Miscellaneous.—*a. Communicable diseases quarantine periods* (see FM 21-10 and FM 8-40).—(1) Measles, 10 days (minimum). German measles, 10 days.

(2) Mumps, 21 days (minimum).
(3) Scarlet fever, 3 weeks (minimum).
(4) Chickenpox, all lesions must be healed. Minimum 10 days.
(5) Epidemic meningitis. Three consecutive negative cultures from nose (both sides) and from throat for meningococci, 5 days apart, taken before discharge.
(6) Typhoid group of diseases, 3 consecutive negative cultures from stool and from urine at 5-day intervals. (Post surgeon should be notified to prevent the assignment of the patient to duties involving the handling of food.)
(7) Dysentery, amoebic or bacillary, same as for typhoid.
(8) Diphtheria, five consecutive negative cultures from nose and throat at 3-day intervals.
(9) Smallpox, until lesions healed.

b. Communicable diseases reportable to Boards of Health.—(1) Amoebic dysentery.
(2) Chickenpox.
(3) Diphtheria.
(4) Epidemic meningitis and meningococcemia.
(5) Erysipelas.
(6) Influenza.
(7) Measles.
(8) Pellagra.
(9) Pneumonia.
(10) Poliomyelitis.
(11) Rocky Mountain spotted fever.
(12) Scarlet fever.
(13) Smallpox.
(14) Tuberculosis.
(15) Tularemia.
(16) Typhoid fever.
(17) Typhus.
(18) Undulant fever.
(19) Venereal diseases.
(20) Whooping cough.

c. Table of normal values in blood examinations.—All amounts for blood chemistries are in milligrams per 100 cc. of whole blood unless otherwise stated, and these values are for bloods taken in the morning after a fast of at least 10 hours.

	Normal	Remarks
Nonprotein nitrogen	25–35	During digestion there is a rise of about 4 mg. per 100 cc. Anything below 30 mg. is to be considered normal, but values up to 35 mg. are to be found without any evidence of kidney retention.
Urea nitrogen	12–17	During digestion of a full meal containing meat, a rise of 2 or 3 or more mg. occurs. In the usual run of clinical cases, values as high as 20 mg. may be encountered.
Creatinine	1–2	In a selected series of normals the upper limit may be as low as 1.7 mg.; 2 mg. is the more common upper limit of normal.
Uric acid	2–4	The figures given are based on Benedict's method which gives somewhat higher figures than does that of Folin and Wu. Values as high as 4.5 mg. are frequently found in bloods, all the other values of which are well within normal range.
Sugar	80–120	During the absorptive period after food there is marked increase, dependent on the carbohydrate content of the food. The extent of this rise after a standard carbohydrate meal is the basis of the "sugar tolerance test."
Chlorides	450–500	Figures for plasma are somewhat higher than those for whole blood; 575 to 625 mg. per 100 cc.
Cholesterol	140–190	Bloor gives an average figure of 210 mg. per 100 cc. and others regard the normal as lying even higher. It is probable, however, that 150 mg. is a fairly representative normal standard.
Calcium	9–11	These values are for the serum alone and represent the total calcium present in the serum after clotting and separation of the clot.
Phosphorus	3–4. 5	These values are for the inorganic phosphorus of the serum after separation from the clot.
Alkali reserve (CO_2 combining power of the blood plasma).	53–77 volumes percent	

	Normal	Remarks
Alkali reserve (alveolar CO_2 tension).	5–5. 5 volumes	These figures are based on the Fridericia method, which represents arterial rather than venous carbon dioxide tension.
van den Bergh	0. 4–0. 8	A van den Bergh unit is equivalent to 1 part of bilirubin in 200,000 parts of serum. The quantitive estimation is made by the indirect test only.
Icterus index	4–6	An icterus index below the normal limit of 4 has so far been found only in cases of secondary anemia. An icterus index of 15 is necessary for jaundice to be evident clinically. Hence, an index between 6 and 15 is termed "latent jaundice."
Total serum proteins	6. 5–7. 5 percent	Low in nephritis with oedema.
Serum albumin	4. 5–5. 5 percent	Low in nephrosis.
Serum globulin	2. 2–2. 5 percent	In lipoid nephrosis the globulin is usually normal and the reduction is in serum albumin giving an inverse ratio.
Albumin-globulin ratio	2–2. 3	In extreme cases variation of 0.2 to 0.5 may occur.
pH of blood.	7. 51–7. 33	
Phosphatase		For adults, 10 units is upper limit of normal. For children, 15–20.
Prothrombin		Howell method, 10–20 minutes. The quotient of Herwitz and Lucas obtained by dividing the unknown by the prothrombin time of a normal person, the normal being 1.0.
Clot retraction time		Begins in 3 to 6 hours; should be complete in 24 hours.
Bleeding time		1 to 3 minutes.
Coagulation time		1 to 4 minutes.
Reticulocytes		0.5 to 2.0 percent.
Platelet count		150,000 to 300,000.
Sedimentation		Cutler method with graph. At the end of one hour normal equals men 0–8 mm., women 0–10 mm.
Shilling count		Segmented neutrophiles, 50 to 70 percent. No myelocyte forms should be present.

d. Normal values for cerebro-spinal fluid (Wechsler, 1939).—(1) Fluid is clear, watery, colorless, alkaline.

(2) Pressure, patient recumbent, 100–150 mm. water; patient sitting, 200–250 mm. water. Queckenstedt, jugular pressure causes sharp rise of pressure to 350–500 mm. water or to 25–5 mm. mercury, followed by sharp fall on release of jugular pressure.

(3) Specific gravity 1,006 to 1,008.

(4) Cells, 0–5 per cubic millimeter over 5 abnormal.

(5) Sodium chloride, 720–750 mgm. per 100 cc.

(6) Globulin, none.

(7) Albumin, trace (2–5 mgm. per 100 cc.).

(8) Total protein, 25–40 mgm. per 100 cc.

(9) Nonprotein nitrogen, 12–18 mgm. per 100 cc.

(10) Glucose, 50–80 mgm. per 100 cc.

(11) Wassermann and Kahn, negative in all dilutions.

(12) Colloidal gold reaction, 0000000000.

e. Sputum collection in pneumonia cases for pneumococcus typing.—(1) (*a*) The importance of proper collection of sputum for typing and examination cannot be overemphasized. Encourage the patient to cooperate and make sure the sputum is a "coughed up" specimen from bronchi and lungs and not "hawked up" post nasal secretions. *This must be personally supervised by the nurse or doctor.*

(*b*) In children one should not depend on coughed up secretions but the specimen should be obtained by aspiration with catheter and 30-cc. syringe. The technique is as follows: One attendant should hold the child's hands and keep the head steady as the operator inserts a tongue depressor toward throat to hold the tongue down and initiate cough reflex. As the child coughs the catheter is gently inserted a short distance in the open respiratory passages. At this moment another assistant quickly manipulates the plunger of the syringe attached to catheter. By pulling the plunger out quickly and returning it somewhat more slowly several times, a specimen is usually obtained. The mucous will adhere to the catheter and it must be forcibly ejected by the syringe into sputum container.

(2) Send the sputum to the laboratory in a sterile petri dish. The sputum record should be marked emergency and the information requested should include—

(*a*) Gross appearance (bloody, rusty, etc.).

(*b*) Gram stain for predominant type of organism.

(*c*) Culture.

(*d*) Pneumococcus typing.

(3) It is very important to decide at once if mixed infection is present or not as use of serum, chemotherapy, or combination of these will depend largely on this decision. If doubt exists or if specific serum therapy has been ineffectual, retyping or recheck for mixed infection is important.

(4) A blood culture should be taken at the same time. If it is positive a check on the type of organism found in the sputum will be available in 18 to 24 hours.

SECTION III

GENERAL SURGERY

233. General routine upon admission.—*a. Ward routine on day of admission.*—(1) Take and record temperature, pulse, respiration.

(2) Notify ward officer or officer of the day of admission and apparent condition.

(3) Bath: Tub or shower for ambulant cases. Sponge for seriously ill. Omit bath in any case in which nurse in charge has a doubt as to its advisability.

(4) Weigh and record weight after bath unless condition of patient contraindicates.

(5) Bed for all patients until otherwise ordered by ward officer or officer of the day.

(6) Urine: Save first urine from emergency cases for gross inspection by ward officer or officer of the day, and send to laboratory for examination.

(7) Diet: Emergency cases nothing by mouth until seen by ward officer or officer of the day.

(8) Abdominal cases nothing by mouth until otherwise ordered by ward officer.

(9) Liquid diet for all other cases until differently ordered by ward officer.

b. Antitetanic serum.—(1) All cases admitted with wounds or burns are given antitetanic serum, observing the following technique:

(2) Approximately 1 minim of the serum to be injected will be injected intradermally with a small skin needle. The raising of a wheal in the skin 1 millimeter in diameter corresponds approximately to 1 minim of the solution. At the end of 15 minutes if there is no reaction around the site of the intradermal injection, the patient can be considered not hypersensitive to the serum and the amount desired can be injected intramuscularly or hypodermically at once. If there is a reaction around the site of the intradermal injection, the patient can be considered hypersensitive to the serum and a desensitizing dose of ½ cc. will be injected, followed in 2 hours by the amount to be used.

(3) The above is a simple test and, unless the case is a "horse asthmatic," is considered safe for practical purposes, bearing in mind that the dose and desensitizing dose for children is in accordance to age and weight.

c. Laboratory examinations.—Laboratory examinations are requested as follows:

(1) *Routine.*—(*a*) Urine, morning after admission.
(*b*) Blood count, red, white, differential, and hemoglobin.
(*c*) Blood Wassermann.
(*d*) Blood coagulation time all nose, throat, and genito-urinary patients.

(2) *As indicated.*—(*a*) Urine, special examination.
(*b*) Sputum.
(*c*) Feces.
(*d*) Nose and throat cultures.
(*e*) Blood chemistry.
(*f*) Blood typing.
(*g*) Blood culture.
(*h*) Stomach analysis.
(*i*) Gastro-intestinal series.
(*j*) Barium enemas.
(*k*) Other examinations.

Care will be exercised to insure that requests for laboratory examinations are specific and that the information asked for will be of value in the study of the case.

d. Special examinations.—(1) *Rectal.*—A digital examination is made in all abdominal and pelvic cases and in other cases as indicated. Proctoscopic or sigmoidoscopic examinations are made as indicated.

(2) *External genitalia.*—Examined in all male cases.

(3) *Vaginal.*—Made as indicated. No vaginal examination in obstetrical cases.

(4) *Blood pressure.*—Taken and recorded in all cases at the original physical examination and thereafter as indicated.

(5) *Eye, ear, nose, and throat.*—The examination is made and recorded in each case at the original physical examination. If special examination is indicated, the case is referred to the eye, ear, nose, and throat section.

(6) *Dental.*—When indicated examination is requested of the dental service.

e. Care of patients.—(1) Temperature, pulse, and respiration every 4 hours from 7:00 AM to 7:00 PM, inclusive, until otherwise ordered by the ward officer.

(2) Baths, daily.

(*a*) Sponges for bed patients.

(*b*) Shower or tub for patients as ordered by ward officer.

(3) Diets: The diet in each case is ordered by the ward officer. The regular diets, liquid, light, and full, are prepared with careful attention to the usual needs. When special diets are required the articles desired will be designated.

(4) Medication is given only on the order of a medical officer. This includes cathartics and enemas.

(5) Teeth of all surgical cases are examined often enough by the ward officer to satisfy him that the proper mouth hygiene is being carried out.

(6) Hot water bags and ice caps are not used without suitable covers.

(7) Ice caps prohibited for post-operative abdominal cases, except on written order of operating surgeon.

(8) All dressings on cases in open wards are done behind screens with the attendants properly gowned, and wearing rubber gloves.

234. Preparation of patient for operation.—*a.* When a patient is listed for operation he is sent to operating room the day before operation for proper shaving (see par. 241).

b. The ward nurse sees that teeth are cleansed and assures herself that urine and blood counts are reported back by the laboratory.

c. The ward officer prepares a preoperative examination report which accompanies patient to operating room.

d. The night before operation the patient is given a light diet for supper and cup of hot chocolate or ovaltine at 8:00 PM, or if preferred, well-sweetened orange juice or cup of hot milk.

e. Preoperative medication, depending on type of anesthesia, is ordered by ward officer (see par. 241).

f. Patient is instructed to void urine before going to operating room, and ward nurse assures herself that false teeth, plates, gum, and glasses are removed from patient.

g. Preoperative preparation of rectal and colon cases for resection only:

(1) After the diagnosis of a colon lesion is established, the patient is hospitalized 3 to 5 days prior to operation.

(2) Patient is given a high caloric, low residue diet.

(3) In most cases a saline cathartic, S. S. magnesium sulphate or a double Seidlitz powder is given, followed by thorough cleansing of the colon by warm compound or Nobel's enema in morning and simple enema in afternoon. These enemas are continued daily until operation. If enemas are not expelled the day of operation they are siphoned off.

(4) Intravenous or subdermal glucose solution in sufficient quantities is given twice daily preceding operation.

(5) Three days (72 hours) prior to operation 1 cc. of Bargen's vaccine mixed with 10 cc. normal saline solution is given intraperitoneally, using a 10-cc. Luer syringe, a blunt spinal needle, with strict aseptic precautions, and given on the side opposite to that of operation.

235. Post-operative care (after patient is returned to bed).—*a.* Not left alone until sufficiently conscious to care for himself.

b. Have basin for vomiting, towel, gauze, tongue forceps, and mouth gag on bedside table ready for emergency while patient is coming out of anesthetic.

c. Patient is kept warm but not to be dehydrated by profuse sweating upon return to the ward.

d. Patient when returned to bed is put in a semi-Fowler position, except after a spinal anesthesia has been given, when the patient has the head lowered.

e. Proctoclysis 25–50 drops per minute, on 2 hours and off 1 hour, of normal saline solution with 1 percent sodium bicarbonate (except after rectal operations) unless otherwise ordered.

f. Catheterization. It is always advisable to delay catheterization and encourage patient to void, even to 18 hours.

g. Give hot water or hot tea freely by mouth as soon as nausea ceases (except in stomach cases).

h. Morphine is ordered as indicated for each case by the operating surgeon or by the ward officer.

i. Measure and record fluid intake by mouth, rectum, hypodermoclysis, and proctoclysis until discontinued by order of ward officer.

j. After gastric or duodenal ulcer cases, drain stomach by stomach tube first night and twice daily thereafter when indicated by dilatation of stomach.

k. Measure and record urine.

l. Measure and record amount of vomitus.

m. Nausea or vomiting, if excessive insert duodenal tube attached to vacuum bottle.

n. Patient during first 48 hours post-operative is turned from side to side assisted by nurse (unless instructed to the contrary).

o. Gas pains and distention: Enemas are not given prior to 48 hours, unless ordered by the operating surgeon. A gas tube may be inserted, except in rectal cases, to relieve distention, and the following mixture to be sipped by patient may be given during first 48 hours for gas pains:

Spirits peppermint, 4 cc.
Sodium bicarbonate, 0.60
Hot water, 60 cc.

Enema effective for gas after 48 hours, designated Nobel's enema, is prepared as follows:

Turpentine, 4cc.
Glycerine, 30 cc.
Saturated solution magnesium sulphate, 90 cc.
Warm water, 90 cc.

p. No cathartic. 48 hours after operation (*except gastric or rectal cases*), give Nobel's enema, and if results are not satisfactory follow 2 hours later with simple enema. In rectal cases, see paragraph 237.

q. Force fluids the first 3 days after operation, at least 2,000 cc. to 3,000 cc. each 24 hours by mouth and rectum, supplemented by intravenous of saline or 5 percent to 10 percent glucose or saline by hypodermoclysis. This is an important part of post-operative treatment.

r. Diet: Hot water or hot tea may be given p. r. n. On second day hot beef or chicken broth may be added. If the required fluids, 2,000 cc. to 3,000 cc. are given as indicated in *e* and *g* above, no other nourishment is necessary until after the bowels have moved as a result of the enema.

s. Post-operative toxic goitre cases are given 10 to 20 drops Lugols solution in 45 cc. grape juice as soon as able to swallow after operation and repeated every 4 hours for first 24 hours, then 10 drops every 4 hours for second 24 hours, and then as surgeon directs. Iced water, cold gingerale p. r. n.

t. Shock: Look for cause and treat as indicated: Raise foot of bed and warm blankets. 1,000 to 2,000 cc. 5 percent glucose intravenously. Blood transfusion when indicated. Adrenalin M 15 of 1 to 1,000 solution by hypo.

u. Removal of sutures: Ordinarily, unless soiled, dressings in clean cases are not changed until sutures are to be removed. Muscle split appendix incisions on the 8th day, and patient to sit up in bed leaning against back rest, and the following day up in a chair and the 10th day to walk.

(1) *Hernia cases.*—Sutures out on the 9th day, but patient is not allowed to sit up until 18th day in bed. 19th day in chair, and the 20th day may walk.

(2) *Right rectus or paramedian incision.*—Sutures out 10th day and to sit up in bed. 11th day to sit in chair, and 12th day to walk.

(3) *Midline incision.*—Sutures out 12th day, and sit up in bed 12th and 13th days, up in a chair 14th and 15th days, and to walk the 16th day.

v. Drainage cases are dressed as ordered in each case.

w. A progress note in clinical record records any wound not healing by primary union.

236. Special post-operative diets.—*a. Routine.*—(1) Hot tea or hot water for the first 24 hours.

(2) Hot water, hot tea, hot beef or chicken broth for second 24 hours.

(3) Liquid for the third 24 hours.

(4) Soft for the fourth and fifth 24 hours.

(5) Light for the sixth 24 hours.

b. Gastric cases.—(1) First 24 hours:

(*a*) 5 percent glucose, intravenous, 1,000 cc. night and morning.

(*b*) Proctoclysis, on 2 hours, off 1 hour (normal saline).

(c) Hot water or tea, 6 to 10 cc. q. 20 minutes if desired.

(2) Second 24 hours:

(*a*) 5 percent glucose intravenous, 1,000 cc. night and morning.

(*b*) Proctoclysis, normal saline, on 2 hours, off 1 hour.

(*c*) Hot water or tea, 6 to 10 cc. q. 20 minutes if desired.

(3) Third 24 hours:

(*a*) 8:00 AM Strained broth of oatmeal, barley, or rice--- 60 cc.

(*b*) 10:00 AM Orange juice sweetened to taste---------- 20 cc.

(*c*) 12:00 M Strained broth---------- 60 cc.

(*d*) 2:00 PM Orange juice---------- 20 cc.

(*e*) 4:00 PM Strained broth---------- 60 cc.

(*f*) 6:00 PM Orange juice---------- 20 cc.

(*g*) 9:00 PM Orange juice ..... 20 cc.
(*h*) Hot water 20 cc. q. 15 minutes if desired.
(4) Fourth 24 hours:
(*a*) 6:00 AM Orange juice sweetened to taste ..... 30 cc.
(*b*) 8:00 AM Strained broth of oatmeal, barley, rice, or peas ..... 60 cc.
(*c*) 9:00 AM Orange juice ..... 30 cc.
(*d*) 11:00 AM Orange albumin ..... 30 cc.
(*e*) 12:00 M Strained broth ..... 30 cc.
(*f*) 2:00 PM Orange albumin ..... 30 cc.
(*g*) 3:00 PM Orange juice ..... 30 cc.
(*h*) 4:00 PM Strained broth ..... 60 cc.
(*i*) 6:00 PM Orange juice ..... 30 cc.
(*j*) 9:00 PM Orange juice ..... 30 cc.
(*k*) Hot water 30 cc. q. 30 minutes.
(5) Fifth 24 hours:
(*a*) 6:00 AM Orange juice, sweetened ..... 100 cc.
(*b*) 9:00 AM Strained gruel of oatmeal, barley, or rice ..... 60 cc.
With strained stewed prunes, apple sauce, or apricots ..... 30 cc.
(*c*) 12:00 M Strained puree of peas, string beans, carrots, spinach, or cauliflower ..... 60 cc.
Beef juice ..... 20 cc.
Fruit ice ..... 16 gm.
Butter ..... 2 gm.
(*d*) 2:00 PM Orange juice, sweetened ..... 100 cc.
(*e*) 4:00 PM Strained gruel of oatmeal, barley, or rice ..... 60 cc.
With strained stewed prunes, apple sauce, or apricots ..... 30 cc.
(*f*) 8:00 PM Orange juice ..... 100 cc.
(6) Sixth and seventh days:
(*a*) 6:00 AM Orange juice, sweetened ..... 150 cc.
(*b*) 9:00 AM Gruel and puree ..... 100 cc.
(*c*) 12:00 M Puree ..... 100 cc.
Beef juice ..... 30 cc.
Fruit ice ..... 30 gm.
(*d*) 2:00 PM Orange juice ..... 100 cc.
(*e*) 4:00 PM Gruel and fruit ..... 100 cc.
(*f*) 6:00 PM Orange juice ..... 100 cc.
(*g*) 8:00 PM Orange juice ..... 100 cc.

(7) Eighth and ninth days:

(*a*) Breakfast:	Wheatena, farina, cream of wheat, thoroughly cooked and strained	200 cc.
	Strained stewed fruit	36–48 gm.
	Hot tea	200 cc.
(*b*) 9:00 AM	Orange juice	120 cc.
(*c*) Dinner:	Baked potato, small and mealy, with square of butter and a little salt.	
	Strained spinach, carrots, peas, string beans, asparagus, or cauliflower	150 cc.
	Beef juice	30 cc.
	Vegetable may be decreased and an equal amount of zweiback or arrowroot crackers soaked in beef juice substituted.	
	Fruit juice	60 cc.
(*d*) 2:00 PM	Orange juice	120 cc.
(*e*) Supper:	Same as breakfast but add 100 cc. of custard junket or gelatine.	
(*f*) 8:00 PM	Orange juice	120 cc.

(8) Tenth day, etc.:

(*a*) Same as ninth day but add soft-boiled or poached egg with a small piece of double toast and butter for breakfast.

(*b*) Add lamb chop, chicken, first, 10 cc. jelly or marmalade with a small piece of double toast for dinner or supper. Strain vegetables and cereals until the fourteenth day.

c. Gastric resection cases.—(1) First seven days, same diet as all gastric cases.

(2) Beginning eighth day:

(*a*) Breakfast:	Same as all gastric cases, *half portion.*	
(*b*) 7:30 AM	Fruit juice	150 cc.
(*c*) 9:30 AM	Eggnog (with zweiback)	150 cc.
(*d*) Lunch:	Same as gastric cases, *half portion.*	
(*e*) 2:00 PM	Fruit juice (with zweiback)	150 cc.
(*f*) 4:30 PM	Supper as for gastric cases, *half portion.*	
(*g*) 6:30 PM	Fruit juice	150 cc.
(*h*) 8:30 PM	Cocoa (with toast)	150 cc.

237. Post-operative care of hemorrhoid and rectal cases.—*a.* First 24 hours:

(1) Hot water and hot tea in moderate quantities allowed at once.

(2) No fluids by rectum.

(3) Hypo morphine sulphate, 0.016 gram (¼ gr.) p. r. n. for pain.

b. Second 24 hours:

(1) Surgical liquids, orange juice, fruit juices, hot tea, hot beef tea, or broth.

(2) For pain or tenesmus give 1 grain codeine, 5 gr. aspirin.

c. Third 24 hours:

(1) 6:00 AM Mineral oil, 20 cc. Repeat at 8:00 PM.

(2) Oatmeal gruel, fruit juices, hot coffee, strained soup.

(3) Continue aspirin and codeine for pain.

d. Fourth 24 hours:

(1) 6:00 AM Mineral oil, 20 cc. Repeat oil at 8:00 PM and add 8 cc. cascara.

(2) Continue diet of third 24-hour period.

(3) Codeine and aspirin for pain.

e. Fifth 24 hours:

(1) 6:00 AM and 8:00 PM. Mineral oil, 20 cc., with 10 cc. cascara.

(2) Add any cooked cereal, baked potato, boiled rice, stewed prunes, and baked apple to diet.

(3) Continue codeine and aspirin for pain. (If given after bowels have moved it will stop tenesmus.)

f. Sixth 24 hours: If bowels have moved, give light diet. Patient may go to bathroom during sixth 24-hour period.

g. Seventh 24 hours: Officer and women patients may be discharged with instruction to continue mineral oil, use damp cloth after bowel movement; give patient three or four doses of codeine and aspirin to take home to be taken if he has tenesmus after bowel movement. Enlisted men and those on enlisted status should remain in hospital about 10 days.

238. Technique for intravenous infusion.—*a* Patient to be screened.

b. Medical officer to wear clean gown and sterile gloves.

c. Glassware and tubing to be sterile and clean.

d. Read the label carefully on solution to be given and be sure it is the correct solution, and that it is a fresh sterile solution.

e. Put folded bath towel under patient's arm.

f. Apply light tourniquet to patient's arm.

g. Paint patient's arm with iodine.

h. Put about 100 cc. of the solution to be given (saline or glucose) in the flask and rinse the flask out with this solution and allow to run out through the tubing to cleanse the tube.

i. Fill flask half full with the solution to be given and get all the air out by lowering the flask while the tube is elevated; repeat if necessary.

j. Have nurse hold the flask and tube while the medical officer punctures the vein. Be sure the needle is open before the vein is punctured. Be sure that the needle is well within the vein, then take off tourniquet.

k. Allow a few drops of solution to run out of the tube to get all air out, then connect with needle.

l. The medical officer is not to leave the patient while intravenous is being given.

m. Upon chilly sensations, weakness, or other evidence of reaction, the infusion is stopped at once.

n. The blood pressure is taken before infusion is started, and the blood pressure apparatus left on. The pressure is taken when the infusion is half completed, and again upon completion. When the pressure is taken during the infusion, if there is a marked rise or fall in the pressure, the infusion is stopped.

o. The intravenous infusion must be given slowly. At least 15 minutes must be allowed for each 500 cc. of infusion.

p. Intravenous therapy is a serious procedure and should be so considered. It must be given carefully and correctly.

239. Severe head injuries, concussion, severe contusion, skull fractures, etc.—*a.* Patient to be put in warm bed on admission to ward, clothing removed with as little disturbance as possible.

b. Blood pressure taken and recorded.

c. Ear and fundus examination made as soon as possible.

d. Ward officer will report case, with essential data to the office, chief of surgical service.

e. All early treatment will be conservative.

f. A consultant from the neuropsychiatric section will be called.

g. Patient *will not* be sent to X-ray section until approved by an operating surgeon and consultant.

240. Report of operation and request for pathological examination.—*a.* The operating report in every instance is signed by the operating surgeon. The diagnosis to be clear and concise and, where multiple conditions, numbered 1, 2, 3, etc., and conform to standard nomenclature. Operations also to be numbered 1, 2, 3, etc., stating simply name of operation. Qualifying remarks concerning diagnosis and operative procedure will be extended on reverse side of Operation Report (W. D., M. D. Form 55 O–2).

b. All operating surgeons personally prepare and sign requests for pathological examination, or direct one of their assistant surgeons to prepare it, with especial attention to a brief description of the specimen and the clinical diagnosis. This information aids the pathologist in reaching his conclusions.

241. Anesthesia and operating room.—*a. Shaving, preoperative.*—Shaving by personnel from operating room day previous to operation except in emergency. After shaving wash field thoroughly with green soap and water. In emergency cases parts will be shaved with dry lather and cleansed with alcohol or ether. No water will be used on skin (reason is that it makes iodine less effective).

b. Anesthetists trained in taking blood pressure.—Anesthetists in operating room will be trained in taking blood pressure. Special blood pressure apparatus attached prior to anesthesia enables anesthetists to take pressure at regular intervals during operation.

c. Preoperative preparation and premedication.—(1) *Spinal anesthesia.*—(*a*) Light supper; nothing by mouth after midnight.

(*b*) S. S. enema at 9:00 PM and 6:00 AM.

(*c*) Sodium amytal 0.195 grams (3 gr.) at 9:00 PM and in the morning 2 hours before the time set for operation.

(*d*) Hypodermic of morphine 0.016 gram (¼ gr.) with scopolamin 0.0004 gram (1/150 gr.) 1 hour before operation.

(2) *Gas oxygen anesthesia.*—Same as the above except for medication. Give morphine 0.016 gram (¼ gr.) with atropine 0.0004 gram (1/150 gr.) 1 hour prior to operation.

(3) *Avertin anesthesia.*—(*a*) Record weight, height, and age, give B. M. R. if known. No laxative for 24 hours before day set for operation. S. S. enema at bedtime. Twenty minutes after S. S. enema give clear water enema. Allow patient to go to toilet to expell enema if able to do so.

(*b*) Sodium amytal 0.195 gram (3 gr.) at bedtime.

(*c*) Hypo morphine 0.010 gram (⅙ gr.) 1 hour before time set for operation.

(*d*) Give no enema in AM.

(*e*) Light supper; nothing by mouth after midnight.

(4) *Colonic ether.*—(*a*) No laxative for 24 hours before operation. Nothing by mouth after midnight. Tea and toast for supper.

(*b*) Two hours after supper give S. S. enema followed at 20-minute intervals by two clear water enemata. If unconscious or uncooperative give colonic irrigation until return is clear.

(*c*) Thirty minutes after last enema, give sodium amytal 0.195 gram (3 gr.) by mouth.

(*d*) In morning exclude visitors.

(*e*) Give clear water enema 2 hours before operation.

(*f*) One and one-half hours before operation give hypodermic of morphine 0.008 gram (⅛ gr.) intramuscularly and a suppository of chloretone 0.640 gram (10 gr.) is inserted. One hour before opera-

tion another hypodermic of morphine 0.008 gram (⅛ gr.) with atropine 0.0004 gram (1/150 gr.) is given and the ether-oil mixture is instilled.

(5) *Ether anesthesia.*—Same preparation as for spinal above, except for premedication. Give morphine 0.016 gram (¼ gr.) (average dose) with atropine 0.0004 gram (1/150 gr.) 1 hour before operation. In emergency cases to be done at once, give morphine 0.016 gram (¼ gr.) and atropine 0.00065 gram (1/100 gr.) at once.

d. Preparation in operating room.—(1) *Surgeons and nurses.*—Hands and arms:

(*a*) Clean nails.

(*b*) Wash hands quickly with plain soap and water.

(*c*) Take sterile brush, dip in green soap and scrub hands, arms, and elbows for 3 minutes, especial attention to scrubbing around nails and between fingers. Rinse off in running water.

(*d*) Use orange stick to clean nails.

(*e*) Take a fresh brush and repeat as in (*c*) above, except the elbows.

(*f*) Hands and wrists immersed in ethyl alcohol.

(*g*) Gowns and gloves: Sterile gown will be put on before wiping hands with sterile towel.

(*h*) Sterile powder is shaken on surgeon's hands by operating nurse.

(*i*) Dry sterile gloves are held for surgeons by operating nurse.

(2) *Patient.*—Skin preparation on table just prior to operation:

(*a*) Two coats of 3½ percent tincture iodine, each coat to be dried with hot air dryer. In the vagina 1¾ percent tincture iodine will be used.

(*b*) Remove iodine with alcohol or sponge stick.

242. Immediate post-operative routine.—*a.* Lighten anesthesia as soon as possible. Rebreathe for 15 minutes with oxygen and carbon dioxide 5 percent until respirations are distinctly simulated, increasing in rate as well as depth. In laparotomies, may begin as soon as the peritoneum is closed. Leave in airway until reflexes are reestablished. Prevent aspiration of vomitus or tongue. In avertin cases, hold up jaw until reflexes return to prevent dropping back of tongue. Keep on back and leave in airway.

b. Record pulse and blood pressure as the patient is about to leave the table.

c. Transfer from table to warm litter with great gentleness and avoid exposure.

d. Have basin for vomiting on litter, also towel, gauze, tongue forceps, and mouth gag.

e. Body and head well wrapped with heated blankets for transportation through corridors to ward.

243. En route from operating room to bed.—*a.* Keep warm.

b. Watch to see that patient does not swallow his tongue or regurgitate and strangle while coming out of ether.

c. Patient not left by operating room orderly and anesthetist until in bed and turned over to ward nurse.

d. Great care exercised in transferring patient from litter to bed.

SECTION IV

ORTHOPEDIC SURGERY

244. Emergency treatment of severe injuries.—In all major acute fractures or fresh wounds with tendon injury, notify the ward officer on call.

a. Examination.—Immediately upon admission such cases should be examined for extent and severity of injuries, location of possible fractures or dislocations, presence of shock. When examining for fractures do not attempt to elicit crepitus, etc. Inspection and gentle palpation will be sufficient to make the diagnosis in most cases. X-rays will supply the necessary information.

b. Fractures.—Fractures should be immobilized immediately by the use of appropriate splints. Splinting reduces pain and shock and prevents further displacement of the fragments, thus preventing further damage to muscles, nerves, and blood vessels. The use of splints in specific fractures is given in *d* below.

c. X-ray.—Anterior-posterior and lateral X-rays should be taken in all suspected fractures or dislocations as soon as patients are admitted. Reduction of dislocations should not be attempted until after X-rays have been taken. If the patient is in serious condition, bedside X-rays should be taken.

d. Emergency splinting of specific fractures.—(1) *Clavicle.*—Clavicular T-splint.

(2) *Scapula, shoulder joint, and humerus.*—Aeroplane splint with 45° to 60° abduction at the shoulder.

(3) *Elbow joint.*—Right angle aluminum splint with a sling.

(4) *Forearm and hand.*—Wood coaptation or aluminum splints.

(5) *Hip, femur, and knee joint.*—Half ring splint with adhesive or ace adherent skin traction.

(6) *Leg, ankle, and foot.*—Cabot splint.

(7) *Pelvis.*—Keep patient supine on hard bed. Tight binder or adhesive plaster about pelvis for support. Determine if there has been injury to the bladder or urethra.

(8) *Spine.*—Special care must be taken in handling patient for X-ray to maintain hyperextension. In all fresh fractures with cord symptoms notify ward officer at once.

(9) *Cervical spine.*—Place neck in hyperextension on a Bradford frame or with a blanket roll under the mattress and apply head traction.

(10) *Lumbar and thoracic spine.*—Place patient on adjustable bed with head to foot of bed and elevate the knee support moderately.

e. Treatment of lacerated wounds and compound fractures.—If wounds were incurred within the last 6 hours, thorough debridement and primary closure. If wounds are between 6 and 24 hours old, thorough debridement and closure with drainage. Wounds over 24 hours old should be considered infected and so treated. Administer A. T. S. (1,500 units) to all cases of lacerated wounds. (Use intradermal test and desensitize if necessary.) When indicated gas bacillus antitoxin should be administered.

f. Nerves and tendons.—In fractures, especially of the arms, the function of the motor nerves should be tested at the time of admission. In all wounds of the extremities careful examination should be made to determine nerve or tendon injury. Recent tendon injuries should receive prompt treatment. Tendons and nerves should be sutured with silk.

g. Fresh wounds.—Fresh wounds should be freely irrigated with warm saline.

245. Preoperative preparation.—Preparation of site of operation:

a Forty-eight hours preceding operation thoroughly cleanse the part with soap and water. Shave and remove all soap with ether. Apply occlusive sterile dressing. On the day preceding operation apply 3½ percent iodine, allow to remain 5 minutes and remove with special thiosulphate solution and again apply sterile occlusive dressing.

b. In cases operated in emergency, use no water but shave dry and cleanse with benzine and ether.

c. Preoperative medication for anesthesia same as general surgery.

246. Post-operative care.—*a.* Fluids as soon as tolerated, beginning with small amounts; may have tap water, tea, and fruit juices.

b. Soft diet when desired unless otherwise ordered. Regular diet after 3 days.

c. In major operative procedures record urinary output for 48 hours.

d. Spinal anesthetic cases may have one pillow after 8 hours except after spinocaine and except when otherwise ordered.

e. Extremities with new casts will be elevated 30° and examined frequently for color, temperature, and sensation. Any unusual local discomfort from casts for splints that is severe enough to keep patient awake will be called to the attention of ward officer or surgical officer of the day.

f. Morphine 0.016 gram (¼ gr.) for pain as necessary every 3–4 hours during first 24 hours, and for severe pain when needed during second 24 hours. For less severe pain and after 48 hours give codeine 0.065 gram (1 gr.) as indicated. Every effort should be made to relieve the patient's discomfort during the post-operative period.

g. Seidlitz powder 48 hours after operation. Mineral oil and cascara daily thereafter as necessary. Decrease or discontinue cascara dosage according to individual requirements. If bowels do not move after seidlitz powders, give enema. Enema may be given any time for distention or discomfort (preceded by 15 minutes by 1 cc. pituitrin on order of medical officer).

h. Temperature, pulse, and respiration taken and recorded on graphic chart until discontinued by ward officer.

i. No visitors while patient is in the recovery room.

247. Plaster casts.—*a. Extremities.*—Extremities with casts should be elevated and supported in comfortable position. Cast should be kept uncovered until dry.

b. Pressure.—Complaints of local discomfort should be promptly investigated and windows cut in the cast when necessary. The heel, malleoli, and lateral surface of the foot in the lower extremity and the medial epicondyle in the upper extremity are common sites of pressure. Nerve pressure on the peroneal nerve and radial nerves are common, and any evidence of weakness of extension of the foot or hand should be promptly investigated.

c. Body casts.—Before application the patient should be prepared with an enema with or without pitressin, and the same measures should be used after application to relieve distension. Casts should be supported to prevent breaking.

248. Traction cases.—Traction apparatus and fracture beds require constant inspection and supervision. All the ward personnel must be alert to discover defects. Patients' complaints must be investigated. Apparently minor maladjustment in splints and traction may cause more discomfort than fractures and operations, and often the patient can be made comfortable with little effort.

a. Fracture beds.—Bed frames will be protected from metal clamps with rubber tubing. Clamps will be in proper position and tight.

b. Splints.—(1) The ring of the half ring splint should fit firmly against the ischial tuberosity. The ring and the skin it contacts must be cleansed and inspected daily by the ward nurse.

(2) The extremith should be well supported with adequate padding.

(3) The foot support should fit properly to prevent plantar flexion deformity.

c. Traction.—(1) Weights must not be released or changed except with permission of the ward officer. Traction *must not* be interrupted in fracture cases. Traction on post-operative knee cases or on amputation stumps may be briefly interrupted for nursing care.

(2) Weights must swing free at all times and not rest on the bed or on the floor.

SECTION V

GENITO-URINARY SURGERY

249. Diagnostic procedures.—Preparation for—

a. KUB, cystogram, lumbar spine.—(1) Cascara 8 cc. or castor oil 45 cc. at 8:00 PM.

(2) S. S. enema at 8:00 PM preceding night and 6:00 AM day of examination.

(3) Light breakfast.

b. Cystoscopy and endoscopy.—(1) Light breakfast.

(2) S. S. enema at 6:00 AM day of examination.

c. Urogram, pyeloscopy, vesiculogram.—(1) Cascara 8 cc. or castor oil 45 cc. at 8:00 PM preceding night.

(2) S. S. enema at 8:00 PM preceding night and 6:00 AM day of examination.

(3) Light breakfast.

(4) 200 cc. water every hour after 5:00 AM.

(5) Precede cystoscopy 3 days with urinary antiseptics.

(6) Morphine sulphate 0.016 gram and atropine 0.00065 gram ½ hour before procedure.

(7) Urogram and pyeloscopy postoperative treatment:

(*a*) Hot bath 20 minutes on return from cystoscopy room.

(*b*) Rest in bed 24 hours.

(*c*) Hot application. Codeine, morphine, and atropine, as necessary for pain.

(*d*) Urinary antiseptics 3 days following examination.

(*e*) Fluid intake minimum 3,000 cc. daily for 3 days.

d. Excretory urograph.—(1) Cascara 8 cc. or castor oil 45 cc. at 8:00 PM preceding night.

(2) S. S. Enema at 8:00 PM preceding night and 6:00 AM day of examination.

(3) Nothing by mouth after midnight.

250. Operation preparation.—*a. General.*—(1) Rest in bed 3 days preceding operation.

(2) Dental prophylaxis and ward care of mouth.

(3) Complete blood and urine examination 48 hours before operation.

(4) S. S. enema at 8:00 PM day before operation and 6:00 AM day of operation.

(5) Light supper day before operation.

(6) Fluids freely until midnight. Nothing by mouth after midnight.

(7) Sodium amytal 0.194 gram or nembutal 0.032 gram at bedtime and ½ hour before operation.

(8) Morphine sulfate 0.016 gram scopolamine hydrobromide 0.0004 gram before sending patient to operating room.

b. Special preoperative requirements and preparation.—(1) Preoperative requirements for cases of prostate hyperplasia and bladder neck obstruction:

(*a*) Complete blood examination, including coagulating time.

(*b*) Complete urinalysis.

(*c*) Wassermann reaction.

(*d*) Blood chemistry, urea nitrogen, sugar, CO_2.

(*e*) Residual urine determination.

(*f*) Catheterization specimen or urine culture.

(*g*) Prostate examination and smear to laboratory.

(*h*) PSP renal function. Concentration and dilution tests.

(*i*) X-ray kidney and bladder.

(*j*) Cystogram as indicated.

(*k*) Excretory urogram as indicated.

(*l*) Examination for the elimination of foci of infection.

(*m*) Minimum total fluid intake 3,000 cc. daily (oral, rectal, and intravenous). Keep record of fluid intake and output.

(2) Preparation of patient for urethral instrumentation, cystoscopy, sounds, dilation, etc.

(*a*) Morphine 0.016 gram and atropine 0.00065 gram before instrumentation.

(*b*) Cleanse external genitalia widely with solution of green soap and water. Remove soap and dry with sterile towel or gauze.

(*c*) Apply bichloride solution 1 to 1,000 to external genitalia with gauze.

(*d*) Drape patient with sterile towels or special sheets according to the extent of the instrumentation.

(*e*) Inject 15 cc. 1 to 500 nupercaine solution into urethra and retain for 10 minutes.

(*f*) Catheterize with flexible rubber catheter, determine residual, obtain specimen for culture, and irrigate with boric acid solution and leave 200 cc. in bladder.

251. Post-operative care.—*a. General.*—(1) Elevate foot of bed 25 cm. for 4 hours following spinal anesthesia unless conditions contraindicate.

(2) Small amount of water by mouth first and second days.

(3) Change position every 3 hours when awake.

(4) Deep breathing exercise every ½ hour when awake.

(5) Morphine 0.016 gram and atropine 0.00065 gram hypo p. r. n.

(6) S. S. enema third post-operative morning.

(7) Fluid intake minimum 3,000 cc. daily, oral, proctoclysis, intravenous.

(8) Prostatectomy cases, give no enema, no proctoclysis.

(9) Liquid petrolatum and cascara p. r. n. after fifth day.

(10) Initiate appropriate treatment of ileus when it occurs.

b. Special treatment.—(1) *Nephrolysis.*—(*a*) Keep patient on back or operative side first 10 days.

(*b*) Elevate foot of bed 25 cm. during first 3 days.

(*c*) Keep patient in bed for 2 weeks.

(*d*) Urogram, renal function, and blood chemistry 5 weeks post-operative.

(2) *Prostatectomy and transurethral resection.*—(*a*) Observe for hemorrhage.

(*b*) No enema. No proctoclysis.

(*c*) Castor oil 45 cc. on morning of third (3d) day.

(*d*) Change dressings p. r. n. to keep patient dry.

(3) *Durapuncture.*—(*a*) Elevate foot of bed 25 cm. for 2 hours.

(*b*) Keep patient in bed for 24 hours.

(*c*) Force fluids 5,000 cc. minimum intake.

(*d*) Light diet.

(*e*) Aspirin, codeine, or morphine as needed for headache.

(4) *Nephrolithiasis.*—(*a*) General routine for genito-urinary cases and clear infection of kidney. Special examination for and measures to eliminate focal infection.

(*b*) General routine and elevate foot of bed 25 cm. for 3 days. Keep patient on back or operated side for 10 days. Bed for 2 weeks.

(*c*) Determination of chemical analysis of calculi and dietary measures to correct causative metabolic defects. (High vitamin diet and acid ash).

(*d*) Two weeks after patient has been up and about make urogram, renal function, and blood chemistry, verifying serum calcium and serum phosphorus.

(*e*) Irrigation of kidney pelvis with 1 percent phosphoric acid weekly after third week.

(*f*) Appropriate urinary antiseptics.

c. Postoperative diet.—(1) First and second days, nothing by mouth except tea and hot water.

(2) Third day, surgical liquids.

(3) Fourth day, surgical soft.

(4) Fifth day, medical soft.

(5) Sixth day, light diet.

d. Care after urethral instrumentation.—Irrigate bladder and instill 30 cc. ½ percent to 1 percent mercurochrome or 1 to 3,000 acriflavine.

252. Urological instruments.—*a. Metal instruments.*—(1) Metal instruments without lights, lenses, or delicate mechanism can be boiled.

(2) Other metal instruments and web catheters, bougies, etc.:

(*a*) Immerse 20 minutes or longer in 4 percent formalin solution.

(*b*) Rinse in sterile water.

b. Uretheral catheters.—(1) Drip a 4 percent formallin solution through them 20 minutes by siphon.

(2) Drip sterile water through them 20 minutes by siphon.

(3) Immerse 20 minutes in 4 percent formalin solution.

(4) Immerse 20 minutes in sterile water.

(5) With sterile gloves inject a few cc. of sterile water in each.

c. Rubber catheters, gloves, etc.—Can be boiled.

253. Special care of prostate obstruction cases.—*a. Preoperative.*—General routine for genito-urinary cases with following special examination:

(1) Routine physical examination. Note cardiovascular renal condition (EKG).

(2) Check for focal infection and institute necessary treatment.

(3) Complete blood examination, including coagulating time and type of blood for donor selection.

(4) Blood chemistry weekly until normal, urea nitrogen, sugar, CO_2, or until no improvement is attained.

(5) Wassermann reaction.

(6) Urinalysis complete twice weekly.

(7) Determination of residual urine.

(8) Specimen of urine for culture.

(9) Rectal and prostate examination with microscopic examination of secretion.

(10) PSP renal function weekly until contraindicated.

(11) Cystogram and cystometric pressure.

(12) Cystoscopic examination unless contraindicated.

(13) Blood pressure daily.

(14) Bladder drainage and irrigation as necessary for urinary retention infection.

(15) Urinary antiseptics.

(16) Daily estimate of fluid intake and fluid output, minimum daily intake 3,000 cc. fluids.

(17) Continue preoperative preparation until maximum renal function and optimum cardiovascular condition have been attained and the vesicle infection has been cleared. Keep patient up and about as much as practicable.

b. Post-operative.—(1) *Suprapubic prostatectomy.*—(*a*) Morphine 0.008 grams as ordered by ward officer.

(*b*) Examine carefully for hemorrhage.

(*c*) Combat shock; lower head; apply hot applications. If systolic blood pressure falls below 80, give 1,000 cc. 5 percent glucose intravenously.

(*d*) Record daily intake and output of water.

(*e*) Examine frequently to ascertain that bladder drainage is maintained.

(*f*) Avoid enema and proctoclysis.

(*g*) Maintain bladder drainage by Connell apparatus.

(*h*) Maintain fluid intake by oral, hypodermal, and intravenous administration.

(*i*) If no hemorrhage occurs, release traction on Pilcher bag at end 2 hours, release fluid in bag at 18 hours.

(*j*) On morning of second day remove Pilcher bag, suprapubic tube, and prevesical drain and place inlaying urethral catheter.

(*k*) After second day irrigate with 30 cc. 10 percent argyrol or 1/2,000 acriflavine solution or ½ percent mercurochrome.

(*l*) Fowler's position as soon as practicable.

(*m*) Patient up in chair fifth or sixth day.

(*n*) Remove silkworm sutures on ninth or tenth day.

(*o*) General post-operative care regarding diet and bowels, etc.

(*p*) Discontinue self-retaining catheter tenth to fourteenth day.

(*q*) Check blood, urine, and renal function before discharge from hospital or earlier if necessary.

(*r*) Cystogram, cystoscopy, and cystometric study before discharge from hospital.

(*s*) Examine cardiovascular system after convalescence and compare with preoperative condition.

(*t*) Begin urethral dilation third to fifth week.

(2) *Perineal prostatectomy.*—(*a*) Examine every ½ hour to ascertain if drainage is satisfactory.

(*b*) Remove perineal gauze at end of 24 hours to 48 hours.

(*c*) Remove perineal drain at end of 48 hours.

(*d*) Remove urethral catheter at end of fifth to seventh day.

(3) *Management of transurethral resection of prostate.*—(*a*) Rest in bed first 2 days. Up in chair on third day.

(*b*) Release traction on the hemostatic bag catheter end of 2 hours.

(*c*) Observe every 30 minutes for hemorrhage during first 6 hours. If moderate hemorrhage occurs, control by bladder irrigation for the removal of clots and by traction on the hemostatic bag catheter.

(*d*) Avoid bladder irrigation in cases in which hemorrhage does not occur.

(*e*) Remove self-retaining catheter at end of second to fourth day. Catheterize 6 hours after catheter is removed; if more than 100 cc. residual urine *leave catheter in place.*

(*f*) Catheterize daily after self-retaining catheter is removed as long as residual urine persists.

(*g*) Avoid purgation, enemata, and proctoclysis. Give mineral oil and fluid extract of cascara as indicated after third day.

(*h*) Maintain fluid intake 3,000 cc. minimum daily.

(*i*) Administer sedatives as indicated, morphine and atropine, sodium amytal.

(*j*) Give urinary antiseptics as indicated and tolerated.

(*k*) Blood count, including hemoglobin and coagulating time, should be done daily during first 3 days.

(*l*) Renal function and blood chemistry recheck should be done during second week.

(*m*) Cystoscopic and cystographic examination should be done at end of third post-operative week.

254. Miscellaneous urological procedures.—*a. Method of catheterization of bladder.*—(1) Cleanse external genitalia with soap solution, dry with sterile gauze, then cleanse with 50 percent alcohol.

(2) Apply towels above and below external genitalia.

(3) Lubricate sterile catheter in the lubricating jelly and insert with sterile forceps.

(4) After withdrawing urine, inject through catheter 30 cc. of 1 to 2,000 acriflavine, inject the last 5 cc. into urethra as catheter is withdrawn.

(5) Sterile rubber gloves will be worn during the above procedure.

b. Urinary antiseptics.—(1) *Urotropin.*—(*a*) Urotropin 2 grams 1 hour AC.

(*b*) Ammonia nitrate 2 grams 1 hour PC.

(2) *Mandelic acid.*—12 grams daily.

(3) *Sulfanilimide.*—2 to 5 grams daily.

(4) *Neutral acriflavine.*—0.5 gram daily. Regulate fluid intake as necessary.

c. Blood and urine examination.—Made twice weekly unless otherwise ordered.

d. Collecting specimen for urine culture.—(1) Prepare as for catheterization.

(2) Discard first portion of specimen.

(3) Collect last portion in sterile container.

e. Provocative Wasserman.—After neosalvarsan is given, specimens are due as follows:

Specimen No.	*Time due*
1	24 hours.
2	48 hours.
3	72 hours.
4	5th day.
5	7th day.
6	9th day.

f. Method of giving enema.—Enema to be given with patient in bed with hips elevated. Give slowly.

g. Urine concentration test.—(1) 6:00 PM the patient is given his usual supper. If he is on a low protein diet, two eggs are added

to this meal; they should be soft-boiled. *This meal is to include no more than 200 cc. of fluids.*

(2) After eating supper, no food or drink is allowed until the completion of the test at 10:00 AM on the following day.

(3) Bedtime patient is instructed to empty the bladder and discard the urine. Any urine during the night will also be discarded. 5:00 AM the following morning the patient should empty bladder, saving the entire specimen in one bottle marked No. 1. 6:00 AM he again is to empty the bladder, saving the entire specimen in bottle marked No. 2. 7:00 AM he again empties the bladder, saving the entire specimen in bottle marked No. 3.

h. PSP and dilution tests.—Give no water before PSP. The patient is not allowed breakfast or drink in the morning of the test. He is instructed to remain in bed for the entire period of the test. Empty the bladder at 7:00 AM. At 7:30 AM he is given exactly 1,500 cc. of water which he is required to drink within 10 minutes. He is furnished with five urine specimen bottles, properly labeled as shown below, and instructed to empty the bladder at the hour shown on each bottle, saving the entire specimen in the proper bottle. After giving PSP:

No. 1, ½ hour.
No. 2, 1 hour.
No. 3, 2 hours.
No. 4, 3 hours.
No. 5, 4½ hours.

i. Care of drainage.—(1) *Kidney.*—Nephrolysis, nephrectomy for tuberculosis (kidney, pelvis, or ureter not opened). Remove drains at end of 24 hours.

(2) *Nephrolithotomy, pelviolithotomy, and ureterotomy.*—Remove drains at end of 4th or 6th day.

(3) *Bladder.*—Remove prevesical drains at end of 24 or 48 hours. Remove paravesical drain at end of 48 to 72 hours.

(4) *Perineal.*—Remove hemostatic pack at end of 24 to 48 hours. Remove perineal drain tubes at end of 48 to 72 hours.

(5) *Ureteral catheters.*—(*a*) Urethral catheters used for drainage or ureteral splints should be removed at end of 48 to 72 hours.

(*b*) Urethral catheters should be changed every 3 days.

j. Administration of tryparsamide.—See paragraph 231*k*.

k. Venereal disease.—Venereal patients are isolated in the hospital for treatment and messing facilities. Each patient is given individual attention and treatment. See circular letter No. 18, S. G. O., 1941.

SECTION VI

EYE, EAR, NOSE, AND THROAT SURGERY

255. Preoperative routine.—*a. General.*—See paragraph 234.

b. Tonsillectomy.—(1) *Adults, local anesthesia.*—(*a*) Light supper night before and no breakfast the day of operation.

(*b*) S. S. enema at 8:00 PM day before.

(*c*) Sodium amytal 0.194 gram (3 gr.) 2 hours before operation. Morphine sylphate 0.016 gram (¼ gr.) and hyoscine hydrobromide 0.00065 gram (1/100 gr.) hypo 1 hour before operation. (Patients under 18 years of age and those who are small or frail should receive two-thirds of the adult hypo.)

(2) *Children, general anesthesia.*—(*a*) Light supper; no breakfast.

(*b*) S. S. enema at 8:00 PM day before.

c. Nasal cases, local anesthesia.—(1) Light supper night before and no breakfast day of operation.

(2) S. S. enema at 8:00 PM day before.

(3) Sodium amytal 0.194 gram (3 gr.) 2 hours before operation. Morphine sulphate 0.016 gram (¼ gr.) and hyoscine hydrobromide 0.00065 gram (1/100 gr.) hypo 1 hour before operation. (Patients under 18 years of age and those who are small or frail should receive two-thirds of the adult hypo.)

d. Mastoidectomy, peroral endoscopy, and other operations.—(1) Treatment is prescribed by ward officer prior to operating, depending upon type of anesthesia, nature of operation, and condition of patient.

(2) An X-ray of chest is taken prior to mastoidectomy.

e. Eye cases, local anesthesia.—Same as *b*(1) above unless otherwise directed.

256. Post-operative routine.—*a. Tonsillectomy.*—(1) *Adults.*—(*a*) Keep patient as quiet as possible in bed.

(*b*) Diet, liquids, water, after 2 hours. Milk, orange juice, or ice cream after 5:00 PM. Soft diet next day. Thereafter the diet may be increased, depending upon patient's condition.

(*c*) Keep patient in bed until second day.

(*d*) Milk of magnesia or other laxative the second night after operation.

(*e*) Mouth wash or gargle of warm normal saline, or other stock preparation beginning the second day.

(*f*) Codeine sulphate 0.032 grams (½ gr.) by mouth at 9:00 PM day of operation.

(*g*) Codeine sulphate 0.032 grams (½ gr.) and aspirin 0.324 grams (5 gr.) p. r. n. beginning second day.

(*h*) Military patients will not be returned to duty until after 1 week from date of operation.

(2) *Children.*—(*a*) Watch carefully until reaction from anesthesia, and watch particularly for hemorrhage at all times.

(*b*) Diet, liquids, water after 2 hours. Milk, orange juice, or ice cream after 5:00 PM. Soft diet next day. Thereafter the diet may be increased, depending upon patient's condition.

(*c*) Milk of magnesia next day, dose depending upon age and size of child.

(*d*) Children will be retained in hospital for at least 24 hours after operation.

b. Nasal cases.—(1) Keep patient as quiet as possible in bed.

(2) Ice compresses to nose for 2 hours after operation.

(3) Remove nasal packing next morning unless otherwise directed. After its removal keep patient in bed for at least 2 hours and longer if indicated.

(4) Diet, liquids, water after 2 hours. Milk, orange juice, or ice cream after 5:00 PM. Soft diet next day. Thereafter the diet may be increased, depending upon patient's condition.

(5) Laxative second night.

(6) Codeine sulphate 0.032 grams (½ gr.) by mouth at 9:00 PM day of operation.

(7) Military patients will not be returned to duty until after 1 week from date of operation.

c. Eye cases.—(1) Patient to be carefully transferred to bed with a nurse or attendant holding the head.

(2) The patient, particularly following intraocular operations such as for cataract, will refrain from all effort or unnecessary movement.

(3) Keep patient on back for 24 hours following cataract operations. After this the patient may be turned on the unoperated side.

(4) Liquid diet for 24 hours and soft diet thereafter until out of bed.

(5) Cataract cases are to be strictly bed patients until otherwise directed.

SECTION VII

DENTAL AND ORAL SURGERY

257. Jaw fractures.—*a.* If a head bandage is in position, or if it is necessary to apply one to stabilize and support the fragments and the overlying soft tissues, the bandage should be so placed and so adjusted as to avoid any distal or backward traction on the mandible. The bandage should act as a cradle and as a stabilizing support.

b. Do not send to main X-ray laboratory for jaw pictures; these will be taken in the dental X-ray laboratory.

c. Keep patient in semi-inclined position, head elevated.

d. Avoid use of hydrogen peroxide as a mouth wash. Use warm hypertonic saline solution.

258. Alveolar abscess.—*a.* Avoid application of external heat.

b. Check elimination and have bowels moving freely.

259. Stomatitis.—*a. Vincent's.*—(1) Have patient rinse mouth thoroughly with sodium perborate, one teaspoonful to one-half glass of warm water. Use three times daily.

(2) Direct patient to brush teeth with soft brush and tooth paste after each meal.

(3) Place patient on soft diet, including orange juice.

(4) Report daily to dental clinic.

b. Mercurial.—(1) The administration of mercury must be discontinued.

(2) Direct patient to brush teeth with soft brush and tooth paste after each meal.

(3) Check degree of elimination and have bowels moving freely.

(4) Report daily to dental clinic.

260. Pulpitis (toothache).—Paint the gum with tincture of iodine. Give patient aspirin 0.640 grams (10 gr.) unless contraindicated. Pack cavity lightly and carefully with a pledget of cotton saturated with oil of cloves.

261. Post-operative care in ward.—*a.* Removal of impacted teeth, multiple extractions, and alveolectomy, and other intraoral surgical operations:

(1) Ice cap to affected parts immediately following return to ward for a period of 4 hours (intermittant application, on 30 minutes and off 30 minutes).

(2) No mouth wash or rinsing for 4 hours (patient can have water to quench thirst).

(3) After 4 hours discontinue ice cap and provide warm hypertonic saline mouth wash. Following 3 days provide warm hypertonic saline mouth wash after meals only.

(4) Aspirin 0.324 gram (5 gr.) and codeine sulphate 0.032 gram (½ gr.) q. 4 hours, p. r. n. during first night if indicated for relief of pain.

(5) Soft or liquid diet for necessary number of days. For edentulous cases, soft diet to be continued until dentures are provided.

(6) Patient to return to dental clinic each morning at 9:00 until otherwise instructed.

b. Fractures of jaw:

(1) Direct patients to rinse mouth with warm hypertonic saline solution after each feeding.

(2) Direct patient to clean teeth with tooth brush as efficiently as possible a minimum of three times a day.

(3) Place patient on liquid diet, unless otherwise prescribed, with feeding from 7:00 AM to 9:00 PM at 2-hour intervals.

(4) If patient should strangle due to nausea or other causes, cut the vertical wires holding jaws together or remove intermaxillary elastics which are more commonly used for intermaxillary traction and fixation. Each patient with intermaxillar wires is provided with a small pair of scissors for this purpose which should be suspended by a cord around the neck at all times.

(5) Record patient's weight weekly.

262. Diet.—Diets to be served on the ward are routinely prescribed by the dental service as regular, soft, or liquid. Diets at the mess hall are prescribed as regular or special jaw diet.

SECTION VIII

ROENTGENOLOGY

263. Gall bladder.—*a. Oral dye.*—The dye is supplied by the pharmacy.

(1) *Single dose technique* (routine for all cases).—(*a*) Evening meal at 5:00 PM, consisting of fruit, vegetables, potatoes or rice, tea or coffee, sugar, water, bread or crackers. *Do not eat cream, butter, other fats, or meat.*

(*b*) Immediately after the evening meal dissolve the dye in a half glass of grape juice and drink all. Tinctura opii camphorata may be given to control diarrhea.

(*c*) Enema of clear water at 7:00 AM the morning of the examination. Repeat *once* if necessary to secure clear return flow, but only *once*.

(*d*) No breakfast, but may have water ad lib, clear tea or black coffee with sugar, *but no milk or cream.* Report at X-ray section at 8:00 AM and 11:00 AM.

(*e*) On return to ward after examination at 11:00 AM, have the patient eat well-buttered toast, two soft-boiled eggs, and a glass of top milk.

(*f*) Return to X-ray section 1 hour after eating the toast, eggs, and milk.

(2) *Double dose technique* (give the second dose only when requested by the X-ray section).—(*a*) The first dose is given according to instructions in (1) above.

(*b*) After the X-ray examination at 8:00 AM ((1)(*d*) above), those patients found to require the *second dose* of the dye will be reported by the X-ray section to the medical officer concerned.

(*c*) Thereafter the examination of these special cases will be conducted as follows:

1. Do not eat cream, butter, other fats, or meat.

2. Eat lunch and evening meal consisting of fruit, vegetables, potatoes or rice, tea or coffee, sugar, water, bread or crackers.

3. Immediately after the evening meal dissolve the second dose of the dye in half glass of grape juice and drink all.

4. After the second dose of the dye follow the instructions in (1)(*e*) to (*f*), inclusive.

b. Intravenous dye.—Ward officer arranges with the chief of the gastro-intestinal section for administration of the dye.

(1) Administration of dye at 4:00 PM.

(2) Remain in bed until following morning.

(3) No supper. (May drink water.)

(4) No breakfast following morning.

(5) No laxatives.

(6) Enema of clear warm water at 7:00 AM the morning of the examination. Repeat if necessary until return flow is clear.

(7) Report at X-ray section at 8:00 AM.

(8) After the examination at 8:00 AM these patients will not be given the "fatty meal" (well-buttered toast, two soft-boiled eggs, and a glass of top milk) until instructions are received from the X-ray section.

(9) Return to X-ray section 1 hour after the fatty meal.

264. Gastro-intestinal.—*a.* No cathartic to be taken during the 24 hours before the series is begun and none until the series is completed.

b. Nothing by mouth from midnight preceding the first examination until after the second examination.

c. Report to X-ray section at 8:30 AM and 3:00 PM.

d. The usual meals are permitted after the 3:00 PM examination.

e. The 24-hour examination will not be made unless requested by the ward officer.

265. Barium enema.—*a.* Castor oil (amount to be prescribed by ward officer) the evening before examination. If castor oil is contraindicated compound licorice powder may be given (approval of ward officer required).

b. Patient may have toast and tea for supper.

c. Enema of clear water at 7:00 AM the morning of the examination. Repeat if necessary until the return flow is clear.

d. No breakfast, but may drink water, tea, or coffee.

e. Report to X-ray section at 8:30 AM.

266. Abdominal region, lumbar spine, sacroiliacs, KUB.—*a.* Castor oil or compound licorice powder.

b. Patient may have toast and tea for supper; no breakfast; may drink water, tea or coffee.

c. Clear warm water enema 1 hour before examination (approval of ward officer required.)

267. Myelography.—*a.* Sodium amytal, 0.195 gram orally the night before.

b. No breakfast; liquids as desired.

c. Sodium amytal, 0.195 gram orally 2 hours before the examination.

d. Shave the hair in the region of the lumbar spine; if cisternal puncture is contemplated shave the hair at the base of the neck up to the external occipital protuberance.

SECTION IX

PHYSICAL THERAPY (FEVER THERAPY) SECTION

268. Class of patients treated.—The officer in charge of fever therapy determines the suitability and dosage of artificial fever in each case submitted. In general this procedure has been found of greatest benefit in—

a. Gonorrheal infection.

b. Syphilis, cerebrospinal.

c. Rheumatic fever.
d. Chorea.
e. Arthritis (infectious).
f. Iritis and other exudative lesions of the eye.

269. Procedure to obtain treatment.—*a.* Requests for treatment are accomplished in duplicate and forwarded with the complete clinical record to the officer in charge of fever therapy. The request is submitted through the respective chief of service.

b. The diagnosis is stated in full on the request for treatment. The clinical record of the patient under consideration is brought up to date prior to submitting the request for treatment and will contain the following data:

(1) Complete diagnosis.
(2) Complete urinalysis report (including acetone and diacetic acid determinations).
(3) Report of complete blood count.
(4) Report of blood chemistry to include sugar, urea nitrogen, and chlorides.
(5) Report of 6-foot X-ray of heart and lungs.
(6) Electrocardiographic report.
(7) Report of kidney function with the phenolsulphonephthalein test.
(8) A statement should be made on the request for treatment that the foregoing diagnostic procedures have been completed.

c. Patients referred are reexamined by the officer in charge of fever therapy who makes final determination of the advisability of this therapeutic procedure as well as the patient's fitness for it.

d. In the event that the case is suitable for treatment the clinical record and duplicate copy of request for treatment are returned to the ward officer. The date of initial treatment is indicated in the appropriate space on the form.

270. Preoperative preparation.—*a.* The day preceding appointment for a fever treatment the patient is given orally either (1) or (2) below, but *not both:*

(1) One *level* teaspoonful of ordinary table salt dissolved in a glass of tap water to be taken in the forenoon and repeated in the afternoon. The ward nurse or attendant will explain to the patient that the glass of salt solution will not be taken all at one time, but only a swallow at a time so that one glass will last throughout the entire forenoon and the other glass throughout the entire afternoon.

(2) Twelve 1-gram enteric coated tablets of salt (NaCl) equally spaced as to dosage and 1,500 to 2,000 cc. of water during the day.

b. A soapsuds enema is given the night before treatment.

c. At 6:00 AM a colonic cleansing enema until the returns are clear is given with plain warm tap water.

d. Breakfast, consisting of tea or coffee and one slice of toast, or three soda crackers, may be permitted, or at the patient's option, may be omitted entirely.

e. The patient is sent to the fever therapy section at 7:30 AM.

271. Treatment.—*a.* The officer in charge of fever therapy determines the length of each fever treatment, the number of treatments to be given in each case, and the frequency of treatments.

b. During the induction and maintenance of fever he is in constant attendance and assures that complete records of the patient's condition and temperature are properly recorded on the appropriate forms. One copy of Fever Therapy Record is completed and forwarded to the ward officer immediately following each fever treatment and becomes part of the permanent clinical record.

c. Post-operative care.—(1) Liquids ad lib.

(2) Diet as requested by patient unless otherwise specified by the officer in charge of fever therapy.

(3) Aspirin 0.65 gram (10 gr.) may be given, or ice cap to head for headache.

(4) Take and record temperature, pulse, and respirations every hour for 4 hours after patient arrives on the ward following a fever treatment.

(5) If patient's oral temperature exceeds 100° F. 2 hours after arrival on the ward, or if the temperature drops to 95° F., or the patient's condition appears unsatisfactory to the nurse, the officer in charge of fever therapy is notified.

d. Routine medications for patients undergoing fever therapy.—(1) Beginning on the day prior to the conditioning or trial fever treatment and continuing daily throughout the entire course of fever therapy, Brewer's yeast is given as follows: One teaspoonful dissolved in small amount of water three times daily after each meal.

(2) Commencing on the day following each fever treatment, beginning with the before breakfast dose, and continuing for eight doses *only*, dilute hydrochloric acid is administered as follows: Ten drops in small amount of water three times daily before meals.

SECTION X

ACUTE POISONINGS, THEIR ANTIDOTES AND TREATMENT

272. Acute poisonings, their antidotes and treatment.

Poisoning	Symptoms	Antidote and treatment
Acetanilide, antipyrin, acetphenotidin (phenacetin).	Face cyanosed. Vomiting occasional. Skin, cold, profuse sweating. Rash simulating measles, scarlatina or pemphigus. Collapse, feeble and irregular pulse, slow respiration.	Lavage. Cathartic. Recumbent position. Stimulation: Brandy. Whisky. Ammonia. Epinephrine. CO_2 inhalation with oxygen. External heat.
Aconite----------	Tingling and numbness of tongue and mouth and sense of formication of the body. Nausea, vomiting. Diarrhea with epigastric pain. Dyspnea. Pulse irregular and weak. Skin cold and clammy. Features bloodless. Giddiness, staggering walk, feeling of heaviness. Mind remains clear. Circulatory collapse. Low blood pressure.	Immediate gastric lavage with H_2O followed by 0.1 percent (1 to 1,000) potassium permanganate, 250 cc. *Avoid emetics.* Cathartics. Stimulants: Caffeine. Adrenalin. Aromatic spirits of ammonia. Whisky. Carbon dioxide and oxygen inhalation if indicated. External heat. Recumbent position with head lower than feet.
Alcohol (ethyl)-------	Ataxia, coma, decreased respiration. Abolition of superficial and deep reflexes. Vomiting. Cerebral symptoms. Dilated pupils. Rapid pulse. Breathing slow and stertorous.	Gastric lavage, weak alkali, sodium bicarbonate (1 dr. to 1 pt.). Coffee by mouth or rectum, or both. CO_2 and oxygen inhalation. Stimulants: Strychnine sulphate (1/30 gr.). Camphor in oil.

Poisoning	Symptoms	Antidote and treatment
Alcohol (ethyl)_____	Pallor of face.	Stimulants—Continued. Atropine sulphate (1/40 gr.). Aromatic spirits of ammonia. Caffeine. External heat. Massage. Opium derivatives are absolutely contraindicated and barbiturates must be used with extreme caution.
Alcohol (methyl)_____ Methyl alcohol is used extensively as a combustible, as a solvent for gums, dyes, resins, and shellacs. It is found in varnish and varnish removers, hat dye, etc.	Dizziness. Headache and vertigo. Staggering gait. Colic, nausea, and vomiting. Dimness of vision progressing to blindness. Delirium, unconsciousness, coma, convulsions, and death.	Immediate gastric lavage and emetic followed by thorough catharsis (magnesium sulphate). Stimulants. External heat. Alkalies freely. Morphine for pain. Pilocarpine sweats and hot packs. Spinal puncture for increased intracranial pressure.
Acid and alkalies_____	Burning pain from mouth to stomach. Evidence of escharotic action about lips and mouth. Difficulty in swallowing. Vomiting and purging of mucus and blood. Skin cold and clammy. Pulse feeble, anxious countenance. Rapid exhaustion. Dyspnea. Collapse. Convulsions. Unconsciousness or coma.	*Do not use a stomach tube.* *Antidotes for—* *Acids.*—Magnesia, chalk, colloidal aluminum hydroxide, magnesium oxide, milk of magnesia. *Alkalies.*—Dilute vinegar, lemon juice, or other dilute acid with plenty of H_2O. 100 to 500 cc. of 0.5 percent Hcl. NOTE.—Antidotes are useless unless the patient is seen a few minutes after the accident. 250 cc. olive oil by mouth. Demulcents such as gelatin, acacia, or flour in H_2O. Stimulant, hypodermically if necessary.

Poisoning	Symptoms	Antidote and treatment
Acid and alkalies		External heat. NOTE.—If an hour or two has passed the treatment must be limited to 1. Aspiration of the thick secretions from the mouth; 2. The administration of fluids with a medicine dropper and small quantities of olive oil as an emollient to eroded surface. *The dangers of a lavage in these cases should not be forgotten.*
Ammonia (caustic)	Gastro-intestinal symptoms as in corrosive poisoning. Purging, usually with pain and straining. Body in cold sweat. Pulse rapid and weak.	*Do not use stomach tube.* Antidotes: Vinegar (1 tablespoonful in a glass of H_2O). Orange or lemon juice. Olive oil, 240 cc. Dilute hydrochloric acid, 2–4 cc. well diluted. Immediate tracheotomy if symptoms of strangulation. Symptomatic treatment. Large quantities of water.
Antimony (tarter emetic).	Astringent metallic taste in the mouth. Heat and sense of constriction in throat. Severe pain in stomach. Incessant vomiting. Diarrhea. Faintness and profound depression. Small, rapid, and weak pulse. Cold, clammy perspiration. Intense giddiness followed by insensibility and death.	Empty stomach with siphon tube. Simple emetics. Strong boiled tea or tannic acid. Stimulants for collapse: Strychnine. Ammonia. Sedatives, when patient is out of immediate danger.
Apomorphine	Prolonged excessive vomiting. Exhaustion and collapse.	Aromatic spirits of ammonia in H_2O or inhalation. Keep patient recumbent. External heat.

Poisoning	Symptoms	Antidote and treatment
Arsenic	Symptoms usually occur within ½ hour to 1 hour after ingestion with a sweetish, metallic taste and a sensation of heat in the mouth and throat. Later there is— Vomiting, profuse. Painful diarrhea. Stools may contain blood and also have the appearance of the rice-water type found in cholera. Urine scanty and suppressed, frequently albuminous. Headache. Chilliness. Fever. Cough. Cramps in the abdomen and limbs. Rapid, feeble pulse, dyspnea, and sometimes convulsions preceding death. Collapse may come early from direct effect on heart or brain, with little pain or gastrointestinal symptoms. Fatal cases have occurred as early as 20 minutes, but patients usually survive 10 to 48 hours or live for a week or more and die of secondary effects. Thirst. Sense of constriction in throat rendering swallowing difficult. Cyanosis. Coma.	Repeated lavage with stomach tube, or emetics, and USP ferri hydroxidum with magnesii oxidum every 15 minutes in 30-cc. doses until three to six doses have been given. Evacuate from stomach in a short while and follow with— Cathartic (caster oil or saline). Milk diet. Opium for vomiting and diarrhea. Intravenous fluids. Stimulants, caffeine and strychnine. External heat. Follow-up treatment should include renal studies for evidence of nephritis. NOTE.—Solutions of iron salts such as tincture of iron chloride, together with magnesium carbonate, sodium carbonate, or any alkali may be used. Milk and chalk powder after lavage may help.

Poisoning	Symptoms	Antidote and treatment
Arsphenamine	Vasomotor collapse (nitritoid crisis). Chills and fever. Angioneurotic edema or urticaria. Exfoliative dermatitis. Severe jaundice and toxemia, nausea, and vomiting. Epileptiform convulsions. Coma.	External heat. Adrenalin chloride and morphine sulfate. Force fluid if no kidney damage. Sodium thiosulphate intravenous (10 cc. 10-percent solution). Sodium dehydrocholate (5 cc. 20-percent solution intravenous).
Atropine—Belladonna	Dryness of mouth. Difficulty in swallowing and articulation. Skin flushed. Thirst. Temperature elevated. Rapid pulse. Dilated pupils. Purging. Delirium.	Lavage with 1 to 1,000 solution of potassium permanganate. Ice cap for delirum. Morphine or barbiturates (during state of excitement only). Stimulants for depression Pilocarpine. Catheterization.
Barbiturates	Coma (deep). Circulatory collapse. Pulmonary oedema. Cold skin and cyanosis. Flaccid paralysis. Absence of reflexes. Presence of barbiturate in blood, urine or stomach washings. (Koppanyi et al test.) Blood pressure low. Pulse small and rapid.	Cover patient warmly (external heat). Gastric lavage if conscious keep head lower than body; if unconscious, apomorphine subcutaneous. (Avoid if marked depression.) Catheterize. Enema and then isotonic glucose by rectum. Strychnine intravenous every 2 hours 1/10–1/20 grain until reflexes return. Caffeine, sodium benzoate. Picrotoxin in 3–10 mgm. dose intravenously every 20 minutes to 1 hour until increase of respiration, rise of blood pressure, or slight twitching of facial muscles. (Physiological antidote.) Camphor, subcutaneous. Fluids, intravenous. Ephedrine.

Poisoning	Symptoms	Antidote and treatment
Barbiturates		Venesection (400–500 cc.) if tendency to congestion. Oxygen and CO_2. 20 cc. of 30 percent alcohol intravenously.
Camphor	Nausea and vomiting. Characteristic odor to breath. Burning pain in stomach. Colic. Giddiness. Face flushed. Pulse rapid and weak. Delirium. Collapse. Coma. Convulsions.	Gastric lavage with warm water, (avoid *oil* and *alcohol*) or apomorphine by hypodermic. High enema. Bartital for excitement, intravenously if necessary for convulsions. External heat. Caffeine or digitalis hypodermically. Carbon dioxide, O_2 inhalations.
Cantharidies	Burning in throat and stomach. Difficulty in swallowing. Vomiting and diarrhea. Salivation and swelling of salivary glands. Burning in urethra. Frequent micturition. Pulse weak and slow. Collapse. Urine, casts, albumin, and red blood cells.	Evacuation of stomach. Lavage with tepid water. Saline cathartic. Warm demulcent drinks (barley H_2O). *No oil by mouth.* Morphine sulphate for pain. Treat as a potential nephritis.
Carbon bisulphide	Odor of carbon bisulphide on breath. Dilated and fixed pupil. Respiratory embarrassment with cyanosis of lips. Shock. Unconsciousness.	Siphon tube and free lavage of stomach. Stimulants, hypodermically and per rectum. Artificial respiration.
Carbon monoxide	Comatose. Skin reddish cyanotic color, lips scarlet red and cheeks flushed. Brownish stippling of skin. Temperature above normal.	Artificial respiration. Oxygen tent (CO_2 5 percent to 7 percent; O_2 70 percent to 80 percent). Cardiac stimulants. Sodium bicarbonate 4 percent and glucose (intravenous or rectum). Absolute rest.

Poisoning	Symptoms	Antidote and treatment
Carbon tetrachloride	Nausea and vomiting. Pain in epigastrium. Faintness. Loss of consciousness. Convulsions.	Immediate gastric lavage. Emetics. Respiratory stimulants: CO_2 and O_2 inhalation. Artificial respiration. Sedation for convulsion. External heat. *Avoid all oils and fats.* Calcium chloride by mouth (only intravenous in moribund cases).
Chemical burns of eye NOTE.—While this subject does not come directly under poisons, it is believed that use may be made in an emergency of these simple directions for the treatment of the above-named condition and the resultant injury minimized and a certain percentage of eyesight saved.		The primary and most important treatment of chemical burns of the eye regardless of the chemical with acid or a base is prolonged copious irrigation with water. Remove debris after prolonged irrigation and apply sterile ointment. Bandage. Efforts at neutralization often result in additional injury to the cornea and should not be attempted when the patient is first seen.
Chloral hydrate	Drowsiness merging into unconsciousness. Slow, labored respiration. Cyanosis of lips. Weak pulse. Subnormal temperature. Contracted pupils. Failure of heart. Delirium. Vomiting, collapse, and coma.	Use syphon tube with free lavage. External heat. Strychnine, subcutaneously. Ether, hypodermically. Stimulants per rectum; caffeine. Artificial respiration if necessary. Avoid alcohol.
Cinchophen (atophan)	Poisoning generally subacute or chronic, but toxic symptoms may become rapidly severe during or in absence of administration of drug.	Gastric lavage. Glucose 10 percent, sodium lactate 2 percent intravenously. 1,000 to 3,000 cc. daily. Duodenal drainage.

Poisoning	Symptoms	Antidote and treatment
Cinchophen (atophan)	Cutaneous manifestations, pruritis, angioneurotic edema, urticaria, rash. Anaphylactoid reaction, rapid pulse and lowered blood pressure. Gastro-intestinal: Ulcer of mouth, nausea, vomiting, and diarrhea. Liver involvement: Jaundice.	High carbohydrate diet, supplemented by between feeding. Candy, Karo syrup. Stimulants (caffeine or digitalis) if necessary.
Cocaine	Dyspnea. Pallor of face, anxiety, fainting. Dilatation and immobility of pupils. Rapid unconsciousness. Convulsions and apnoea. Pulse abnormally rapid at first, quickly slows down and becomes intermittent and feeble. Asphyxial manifestations in fatal cases. If death does not occur in a few minutes, recovery always follows.	Empty stomach with siphon tube. Lavage with dilute solution of potassium permanganate, 1 to 1,000 solution, or tannic acid, 5 grams. (Above only in cases of oral administration.) Strychnine 1/30 grain and inhalation of ammonia. Coramine, 1–2 cc. intravenously. Sodium amytol, 10-percent solution, 3 grain intravenously. Artificial respiration and O_2 in threatened asphyxia.
Copper (blue stone)	Pain in mouth, throat, and stomach. Bluish or greenish discoloration of membrane of mouth. Vomiting, blue or green vomitus. Diarrhea accompanied by collicky abdominal pains. Convulsions, paralysis. Coma. Death.	Siphon tube. Free lavage with albuminous and demulcent fluids (egg white and acacia). Antidote, potassium ferrocyanide 0.65-gram doses in warm H_2O.
Cyanides	Violent convulsive seizures. Insensibility. Odor of prussic acid on breath or in vomitus. Face cyanotic. Dyspnea.	Immediate use of siphon tube. Freed lavage with warm H_2O alone or containing 10-percent sodium thiosulphate or mixture of

Poisoning	Symptoms	Antidote and treatment
Cyanides	Foam or froth at the mouth. Jaws tightly clenched. Respirations jerky (hic-coughing). Pulse small and rapid. Eyes staring and fixed with marked dilatation of pupils. (May occur following fumigation of ships or buildings; photography; electroplating; gilding.) If patient survives 1 hour, recovery may occur.	ferrous and ferric sulphates followed by potassium carbonate (Prussian blue). Hydrogen peroxide diluted 1 to 16 may be used. Emetics if tube not available. Stimulants: Strychnine. Caffeine. Ammonia inhalations. Artificial respiration and O_2 and CO_2 (7 percent). Atropine hypodermically. Sodium thiosulphate, 20-percent solution, 10 cc. intravenously. Metylene Blue (1 cc. of 0.1 percent Mercks medicinal methylene blue *in Ringers solution* per kilo of body weight) intravenously. *Probably best treatment.*—1. Immediate administration of amylnitrite by inhalation, repeating every 2 to 3 minutes until ready to give nitrite intravenously. 2. Intravenous injection of sodium nitrite, 6 to 10 mgm. per kilogram of body weight, followed by intravenous injection of sodium thiosulphate, 0.5 gram per kilogram of body weight (it is important that the two substances should not be mixed in the syringe). 3. Gastric lavage, if poison was taken by mouth. 4. Continuous observation of patient for 48 hours with repetition of the antidotes in half dosage in 1 hour if symptoms threaten to

Poisoning	Symptoms	Antidote and treatment
Cyanides		return and in any case, a repetition (half dose) in 2 hours for prophylactic purposes.
Digitalis	Nausea, vomiting, followed by abdominal pains and diarrhea. Pulse slow. Feeling of faintness and precordial oppression. Respiration, slow and sighing. Drowsiness which proceeds to coma. Coupled beats and sometimes runs of ventricular tachycardia. Convulsions may precede death.	Stop administration of the drug. Gastric lavage with 1 to 1,000 solution potassium permanganate or 1 percent tannic acid. Atropine, hypodermically. Aminophylin. External heat. Glucose intravenously.
Ergotamine tartrate (ergot).	Pain in stomach. Nausea and vomiting with or without blood. Thirst, numbness and tingling of hands and feet. Weak, rapid pulse. Feeling of oppression in chest. Subnormal temperature. Coldness of body. Cramps, convulsive movements. Stupor delirium and coma.	Use of siphon tube. Lavage with warm H_2O or diluted tannic acid (1 percent). Purgation with magnesium sulphate or castor oil. Stimulants: Brandy. Ammonia diluted with H_2O. Amyl nitrite. External heat. Inhalation of oxygen and carbon dioxide.
Formaldehyde	Odor. Sore mouth. Dysphagia. Severe abdominal pain. Unconsciousness and collapse. Later, diarrhea and tenesmus.	Empty stomach with siphon tube. Lavage with tepid water. Ammonia internally: 4-cc. doses of aromatic spirits of ammonia or 2-cc. doses of diluted ammonia in 250 cc. of H_2O.
Chlorine, bromine, and iodine (especially iodine).	Intense burning and pain in mouth, throat, gullet, and stomach. Corrosive lesions and staining may be seen in mouth and throat. Swelling of these parts.	Gastric lavage with flour, soup, or thin starch paste in water. May lavage with solution of 1 percent sodium thiosulphate. Apply external heat. Stimulants if indicated.

Poisoning	Symptoms	Antidote and treatment
Chlorine, bromide, and iodine.	Vomiting, and sometimes, purging. Signs of shock. Violent, convulsive, and irrespressible coughing. Dyspnea; thirst; giddiness; faintness; convulsions. Stools may contain blood.	Sodium thiosulphate 1 to 10 grams by mouth as antidote. Well diluted. Sodium bicarbonate as follow-up treatment. General symptomatic measures.
Lead (inhalation, ingestion, and through skin).	Metallic, astringent taste in mouth. Burning, pricking, or dry sensation in throat, gullet, and stomach. Thirst. Abdominal pain, colic. Nausea and vomiting. Diarrhea, giddiness, stupor, faintness and convulsions. May have constipation or delirium. Stools are black if and when passed.	Empty stomach by emetics or by gastric lavage with water containing Na_2SO_4 (4 to 6 oz.), magnesia, or dilute H_2SO_4. Demulcent drinks. Cathartic after lavage. Apply external heat. Calcium gluconate intravenously. Symptomatic. Vitamin C and high calcium later in chronic stage. Opiate for colic.
Mercury (corrosive sublimate, bichloride, mercuric chloride, mercuric oxide (red precipitate), ammoniated mercury (white precipitate), and other irritant salts of mercury).	Metallic, acrid taste in mouth. Sense of constriction or suffocation in throat. Burning heat down gullet into stomach. Tongue may be white and shriveled. Violent pain in region of stomach, increased by pressure which initiates nausea and vomiting. Profuse diarrhea with severe tenesmus. Skin cold and clammy. Pulse small, feeble, and rapid, may be irregular. May get swelling of glottis with asphyxia. Respirations difficult.	*Treatment in detail.*—1. Immediate gastric lavage with a saturated solution of sodium bicarbonate, temperature 100° F. This is continued until the return fluid is clear. The lavage is repeated every 12 hours for the first 5 days and is continued over a longer period if the chemical analysis of the washings show mercury. 2. Morphine sulphate is administered immediately after the primary gastric lavage. This is repeated at intervals dependent upon the degree of shock, vomiting, and pain; but the fundamental should be to relieve discomfort, retching, and shock. 3. Sodium bicarbonate, 500 cc.

Poisoning	Symptoms	Antidote and treatment
Mercury		of a 5-percent solution, is given intravenously immediately after the lavage, and 1,000 cc. of normal saline solution administered subcutaneously. As long as vomiting persists the same amount of each solution is repeated every 12 hours. 4. Sodium bicarbonate 5 grams is given orally every 3 hours during the day and every 4 hours during the night. The amount of bicarbonate may be varied provided the urine is kept alkaline to litmus. 5. The total daily fluid intake must be at least 5,000 cc. for an adult, and this amount must be maintained by oral, subcutaneous, or intravenous route, dependent upon the ability of the patient to retain the substances taken orally. Preference is always given the oral method. 6. The daily diet is orange juice 500 cc., milk 1,000 cc., and beta lactose 100 grams. One egg daily is added as soon as vomiting is controlled. The feedings should be given every 3 hours. If vomiting interrupts the feeding schedule, 10-percent glucose solution is given intravenously in amounts sufficient to maintain an intake of at least 1,000 calories. The bicarbonate solution can be made with the glucose solution and the injection given by the intravenous "drip"

Poisoning	Symptoms	Antidote and treatment
Mercury		method. After the first week adequate nutrition and medication are in some cases interrupted by the development of a severe stomatitis and esophagitis. 7. A colonic irrigation, using 5-percent sodium bicarbonate solution is given daily and is continued until recovery is assured.
Morphine and other members of opium group (opium, morphine, codeine, ethylmorphine hydrochloride, dionin, heroin).	Period of excitation and period of narcosis. First seldom seen in poison cases. Overpowering condition of drowsiness, gradual in onset. Cyanosis. Profound insensibility so that no stimulus can arouse; coma. Relaxation of muscles. Pulse small and weak. Breathing labored, noisy, may be irregular; later becomes slow and shallow. Convulsions. Skin pale, cold, and bedewed with clammy perspiration. Pupils contracted to almost pinpoint size. They may dilate terminally. Death may succeed deepening of narcosis or may be preceded (especially in children) by convulsions. Symptoms may remit for a time, but return in all their original severity.	May use emetics if not narcotized. Gastric lavage with solution of $KMnO_4$(1 to 1,000 solution). Repeat lavage in ½ hour. May repeat several times thereafter. Some of the $KMnO_4$ solution should be left in stomach after the lavage. Medicinal charcoal may be given by mouth. Keep patient warm and awake. Atropine sulphate (.0065 gm) may be given. Stimulate with coffee (2 cups, strong), caffeine, sodium benzoate by hypodermic, strychnine, or coramine. Artificial respiration if necessary. 5-percent CO_2 and oxygen mixture or oxygen alone.
Mushrooms	General malaise. Profound asthenia, prostration.	Emetics or gastric lavage. Bed rest. Application of heat.

Poisoning	Symptoms	Antidote and treatment
Mushrooms	Nausea, vomiting, and diarrhea. Severe abdominal pains, colic. Convulsions and coma. Contracted pupils, fixed. Salivation, lacrimation, and perspiration (profuse). Pulse slow. Jaundice (hemolysis) and renal damage. Spasms, paralysis, agitation, cramps in calves. Stertorous respiration. Extremities cold.	Saline purge. Medicinal charcoal or tannin. *Bolus alba*, repeatedly. Saline and glucose by mouth and per rectum. Force fluids; diuresis. Caffeine, strychnine, coramine, analeptics, and sedatives, morphine, *atropine*, blood transfusions as indicated by the symptoms of the individual case.
Nicotine	Nausea and vomiting. Convulsions. Dyspnea; quickened respiration. Collapse, coma. Headache, giddiness, dizziness, numbness, disturbance of vision, torpor, faintness, intense depression, weakness, cold extremities, salivation, nasal discharge. Feeble, rapid and irregular pulse, pallor, cyanosis. Tremors, weak tendon reflexes, dermographic reaction, anisocoria, apathy. T-wave reversed, E. K. G. Tachycardia, bradycardia, leukocytosis, glycosuria. Pupils first contracted, then dilated.	Induce vomiting by giving large quantities of warm water apomophine (0.0065 gm), or zinc sulphate. Gastric lavage with 1 to 1,000 $KMnO_4$ solution in warm water. Bed rest for 24 hours. Force fluids. Saline diuretics. Saline purges. Caffeine, strychnine, or atropine as indicated in individual case. Also aromatic spirits of ammonia. Medicinal charcoal may be used. Keep patient quiet and in horizontal position. External heat, artificial respiration, if indicated.
Oils (turpentine, eucalyptus, savin, juniper, pennyroyal, tansy, or wintergreen).	Characteristic odor on breath. Burning in mouth and stomach. Nausea and vomiting. Colic and diarrhea. Giddiness, drowsiness, unconsciousness, coma. Thirst, hematuria, jaundice. Pulse fast, thready, feeble.	Gastric lavage with tepid water or with solution of $NaHCo_3$. Wash until odor of oil is gone. May give emetics. Purgative dose of $MgSo_4$. Application of heat. Demulcent drinks (starch or flour in water, white of egg, oatmeal, arrowroot, or acacia in water).

Poisoning	Symptoms	Antidote and treatment
Oils	Skin moist and clammy, cold, and blue. Pupils dilated and immobile. Methemoglobinemia, hematuria. Sometimes uterine hemorrhage or abortion.	Force fluids. Keep patient recumbent. Morphine as needed for pain. Sedatives, stimulants, and intravenous fluids as indicated in individual case. Barbiturates for excitation. Later treatment for nephritis and hepatitis.
Oxalic acid (potassium binoxalate, hat bleach, ink eradicator).	Burning acrid taste on swallowing. Severe and continuous vomiting, sometimes bloody. Burning sensation in gullet and stomach. Sense of suffocation, loss of voice. Livid countenance; cold, clammy skin. Hurried respirations; pulse rapid, weak. Pain and tenderness in abdomen. Purging and tenesmus. Convulsions, headache, collapse, coma.	Gastric lavage, $KMnO_4$ solution. (1 to 1,000 solution.) Administer chalk, or lime, with milk; or other demulcent drinks in small, concentrated quantities. Milk of magnesia. Magnesium carbonate in large amounts of water. Intravenous $CaCl_4$, calcium lactate or gluconate. Leave some $KMnO_4$ solution in stomach. Apply heat to body. Stimulants if necessary.
Paris green (arsenite and acetate of copper).	Symptoms usually appear in from ¼ hour to 1 hour. Burning heat and constriction or choking in throat, rendering swallowing difficult. Nausea and incessant vomiting and purging. The vomiting matter may be green from bile, or, in the case of arsenic, black from the admixture of soda, or blue from indigo. Pain in the stomach and abdomen. Cramps in the calves of the legs. Urine may be suppressed. There may be delirium or paralysis. Collapse; skin cold and	Abundant gastric lavage with warm water. Infusion of solution of sodium chloride if necessary. Tincture of opium for diarrhea and colic. Caffeine, strychnine or atropine, as needed, for circulatory and respiratory stimulation. Milk diet. Treat as for potential nephritis.

Poisoning	Symptoms	Antidote and treatment
Paris green	clammy, sometimes showing eczematous rash. Pulse small, quick and irregular, or imperceptible.	
Phenol (carbolic acid, cresol, lysol, crealin).	Characteristic odor on breath. Intense burning in mouth throat, and stomach. Nausea and vomiting. Burns on lips or in mouth. Coldness and clamminess of skin; small thready pulse. Abdominal pain. Stertorous, labored, or hurried breathing. Early onset of insensibility; subnormal temperature. Faintness, collapse. Pulse slow and weak. Urine scanty with smoky color.	Evacuation of stomach by emetics or lavage. Can put $MgSO_4$ in the lavage water, leave some in stomach. Animal charcoal. Demulcent drinks. Rectal feeding for a few days. Stimulants as indicated by symptoms. Apply external heat. *Artificial respiration* or parenteral fluids as indicated. For external burns, use alcohol locally.
Phosphorus (rat poison *paste*).	Early symptoms are— Pain in stomach, slight at first, severe later. Vomiting. Garlic taste in mouth, garlic odor on breath. Great thirst, burning sensation in throat and gullet. Vomitus dark, coffee-colored, has garlic odor, phosphorescent in the dark. Shock. Late symptoms are (possibly after an intermission of 3 or 4 days)— Convulsions and coma. Jaundice, severe; liver, and perhaps spleen enlarged. Distended abdomen. Hemorrhages from nose and other mucous membranes.	200 cc. of 0.2-percent solution of copper sulphate by mouth. Lavage with from 5 to 10 liters of the same solution followed by lavage with 1 liter of 0.1-percent *potassium* permanganate, followed by the administration of 100 cc. of liquid petrolatum. No fats or oils should be given, as they aid absorption. External heat. Treatment continued for liver injury, high carbohydrate diet; dextrose and insulin (5 percent dextrose in Ringers solution).

Poisoning	Symptoms	Antidote and treatment
Phosphorus	Great prostration, feeble pulse, muscular twitchings. Hyperpyrexia.	
Quinine and quinidine	General asthenia; weakness in limbs. Tinnitus aurium, deafness. Nausea, vomiting, and severe abdominal pain. Great excitation, hallucinations, delirium, hyperesthesia or anesthesia of extremities, muscular contractions with clonic or tonic convulsions, exaggeration of reflexes, semicoma with lucid moments. Intense headaches with limitation of vision (especially retraction of visual fields). Later deafness and blindness. Hypotension, small pulse, bradycardia.	Produce vomiting with emetics or lavage, stomach. Intramuscular injection of acetylcholine (2 mg.). Inhalations of amyl nitrite. Strychnine (1 mg.). Caffeine. Tannic acid by mouth. Use $KMnO_4$ (1 to 1,000) as lavage. Sedatives if indicated. Barbital by mouth if excitation persists.
Salvarsan oral (for intravenous see arsphenamine).	Rigors. Pyrexia. Prostration. Headache, giddiness. Anorexia, vomiting, colic diarrhea. Jaundice (later). Rapid pulse, cardiac symptoms, difficult breathing. Psychic and motor restlessness. Bladder symptoms. Skin eruptions (herpes, urticaria, etc.). Oedema and cyanosis of face. Tonic and clonic convulsions of limbs. Thirst; dry throat and larynx.	Emetic ($ZnSO_4$ or mustard water to which hydrated ferric oxide (freshly prepared) has been added). Allow some of solution to remain in stomach. Can use milk of magnesia or even $NaHCO_3$. Epsom salts. Glucose and saline intravenously. Demulcent drinks later. Symptomatic therapy.
Sodium fluoride (roach powder).	Sudden development of nausea and vomiting, accompanied by burning, cramp-like abdominal pains and diarrhea.	The important consideration in the treatment of sodium fluoride poisoning is the employment of calcium containing

Poisoning	Symptoms	Antidote and treatment
Sodium fluoride	Clonic convulsions have occurred in occasional cases. A peculiar grayish blue cyanosis has been observed in some cases, possibly due to the formation of fluormethemoglobin. Death is apparently due to the direct action in the cardio-respiratory centers in the medulla. The blood and urine may be analyzed chemically for the presence of sodium fluoride.	substances in order to convert the soluble sodium salt to insoluble calcium fluoride. This is best accomplished by copious, repeated gastric lavage with lime water or a weak solution of calcium chloride, and by the intravenous injection of calcium chloride or intramuscular injection of calcium gluconate. In addition, for cyanosis and collapse, oxygen inhalations, coramine and atropine.
Strychnine (nux vomica, dog buttons, picrotoxin, fishberries brucin)	Bitter taste in mouth. Lividity of face. Sensation of suffocation. Jerking or twitching of the muscles of the body, neck, and limbs followed by severe tetanic convulsion of all the muscles of the body—opisthotonus. Breathing becomes difficult and imperfect; cyanosis of face develops. Risus sardonicus; eyes staring and wild looking. Trismus (passes off during periods between convulsions but this is not true in tetanus). Senses preserved; has great pain.	Give by mouth or with stomach tube, suspension of medicinal charcoal, 2 tablespoonsful in glass of water, or tannin in water. Use $KMnO_4$ solution (1 to 1,000 for gastric lavage). Artificial respiration if it becomes necessary. *Do not use emetics.* For sedation use barbiturates as follows: 1. When sodium amytal or sodium pentobarbital is used just enough of the intravenous preparation is given to put the patient to sleep, or, if in convulsions, to stop them. (The patient will usually go to sleep.) 2. When phenobarbital sodium is used, a quantity just sufficient to stop convulsions should be given, even though sleep is not induced. 3. When the patient shows further symptoms of strychnine poisoning, as indicated by heightened reflexes,

Poisoning	Symptoms	Antidote and treatment
Strychnine		complaints about noises marked response to slight stimuli, or convulsions, the antidote should be repeated. 4. Gastric lavage is unnecessary and not advisable but may be done after the patient is asleep if adequate help is available to prevent injury or aspiration of material from the stomach. 5. Physiologic solution of sodium chloride may be given intravenously, but this is not necessary. 6. Quiet, dark surroundings are recommended. 7. One should distinguish between the effects of the barbiturate and the action of strychnine when repeating the injection. This may occasionally present a real difficulty, and when doubt exists it is wise to await a mild convulsion before giving the second or third dose of barbiturate. 8. The dose to be given cannot be calculated unless definitely certain of the amount of strychnine ingested, the amount of strychnine absorbed, and the weight of the patient. Idiosyncrasy to either the poison or the antidote may then change it. 9. Morphine is not indicated and apomorphine may prove dangerous in that aspiration of material from the stomach may occur. 10. Ether may well be used to control convulsions until a soluble barbiturate can be given. If

Poisoning	Symptoms	*Antidote and treatment*
Strychnine		an intravenous preparation is not available and the patient is not in convulsions, amytal, phenobarbital, pentobarbital, or other barbiturates may be given by mouth, the amount not to exceed the equivalent of 15 grains of sodium amytal for an adult. The intravenous preparation can then be given later, if necessary.

CHAPTER 5

STATION HOSPITAL

273. Function.—*a.* A station hospital normally receives patients only from the station to which it pertains. In exceptional instances it may, however, serve the needs of a circumscribed area, or may be designated to receive special cases from any place within a corps area or other military command under the control of whose commander it functions. A station hospital in peace or war functions under local, district, section, or corps area control as may be prescribed by the superior commander under whose jurisdiction it is being administered.

b. For utilization in a theater of operations, a station hospital has a normal capacity of 250 beds. In the zone of the interior, station hospitals vary in size from 25 to 2,000 beds, depending upon the local demands for hospitalization.

274. Designation and identification.—See paragraph 2.

275. Organization.—The general organization of a station hospital is in conformity with AR 40-590 and limitations of existing Tables of Organization.

a. The organization consists of two major divisions:

(1) Administrative.

(2) Professional.

b. The administrative division consists of personnel and activities as follows:

(1) Commanding officer.

(2) Medical inspector.

(3) Registrar (including commanding officer, detachment of patients).

(4) Medical supply officer.

(5) Mess officer.

(6) Commanding officer, medical detachment.

(7) Chief nurse.

(8) Officer in charge of utilities.

All *personnel* are under the *immediate* supervision of the commanding officer. Those in charge of each activity are responsible

directly to him for the proper conduct and administration of their respective departments.

c. The professional division may consist of services subdivided into various sections and clinics as follows (see fig. 1):

(1) Surgical service:
Anesthesia.
General surgery.
Orthopedics.
Obstetrics and gynecology.
Urology.
Eye, ear, nose, and throat.
Roentgenology and physiotherapy.

(2) Medical service:
General medicine.
Contagious.
Neuropsychiatry.
Detention.
Dermatology.

(3) Laboratory service.

(4) Dental service.

(5) Dispensary and out-patient service (formerly attending surgeon).

276. Similarity between general and station hospitals.—The administrative and professional procedures of a station hospital differ from those outlined for a general hospital only in minor details. These differences are those occasioned by a different type of command control, and type of patient. The actual methods of treatment, record keeping, and administration are similar. The procedure outlined as applicable to general hospitals may be modified to meet those conditions existing in station hospitals. See AR 40-590 and preceding chapters, this manual.

Appendixes I to XIV, inclusive, contain check lists for the use of the various unit staff offices in station or general hospitals. These lists will provide a uniform method of periodic check for those responsible for hospital administration, and will aid medical officers without prior military experience in not only what should be expected, what to look for, what is important or trivial, how to make comparisons, but also where to find a solution to the problems with which they will be confronted. All references to Army Regulations, Field Manuals or Technical Manuals, War Department Circulars, circular letters, Office of The Surgeon General, etc., are quoted as of April 1, 1941. Due care will be exercised that changes to the publications listed and current additions are consulted for later methods or procedures.

APPENDIX I

CHECK LIST FOR MEDICAL (HOSPITAL) INSPECTOR

1. Command.—*a.* Composition of the command (component parts) and the number of officers, warrant officers, nurses, and enlisted men in each organization (AR 40–1025).

Organization Officers Warrant officers Nurses Enlisted Prisoners Civilians Total

b. Mean strength of the command for the last month (AR 40–275).

Military_____ Civilian_____

2. Environmental sanitation.—*a. Drainage system.*—Includes grounds and efficiency of drainage from a sanitary point of view and sewage disposal system.

(1) Any material changes in the topographical features which would affect the drainage system. If so, state changes.

(2) Any changes in the methods used to dispose of excreta, to include the sewerage system and sewage disposal plant, since date of last December sanitary report. If so, state the change (AR 40–205 and AR 40–275).

(3) Methods of sewage disposal satisfactory. If not, state changes to be recommended (AR 40–275).

(4) System and the sewage disposal plant is satisfactory. If not, state changes to be recommended (AR 40–275).

b. Public buildings.—Includes barracks, hospital, quarters, etc., guard house, mess halls and kitchens, bakeries, exchanges, barber shops, commissaries, meat markets, theaters, swimming pools, stables, picket lines and corrals, and service clubs.

(1) *Barracks, hospital, quarters, etc.*—(*a*) Any changes in the buildings since the last medical inspection. If so, state changes (AR 40–275).

(*b*) Barracks, hospital, quarters, and other buildings are suitable and maintained in a sanitary condition (AR 40–275).

(*c*) Barracks buildings are suitable for habitation from the standpoint of health and sanitation. If not, state deficiencies and recommendations (AR 40–205).

(*d*) Each man sleeping in a squad room or dormitory has at least 60 square feet of floor space and 720 cubic feet of air space computing a maximum ceiling height of 12 feet (AR 40–205).

(*e*) Each dormitory has been surveyed and the authorized capacity of men has been stenciled upon the doors (AR 40–205).

(*f*) Beds are grouped too closely together in order to obtain space for other purposes (AR 40–205).

(*g*) If less than 5 feet of space exists between side bars of adjacent beds head and foot sleeping is required (AR 40–205).

(*h*) Sleeping rooms adequately ventilated both by day and night (AR 40–205).

(*i*) Floors of sleeping rooms show evidence of having been scrubbed with soap and water at frequent intervals (AR 40–205).

(*j*) Company commanders require that bedding be aired at least once a week (AR 40–205).

(*k*) Beds in squad rooms are clean (AR 40–205).

(*l*) During the summer season screens are used in all occupied buildings to prevent ingress of flies and mosquitoes (AR 40–205).

(*m*) Toilet bowls are in good condition, seat covers attached, and without accumulations of sediment (AR 30–1760).

(*n*) Toilet flushing apparatus is in working order (AR 30–1760).

(*o*) Urinal troughs are adjusted properly as to height and pitch, with flushing facilities present, and kept in a sanitary condition (AR 30–1760).

(*p*) There are sufficient working shower heads for the strength of the organization (AR 30–1760).

(*q*) Lattice stands and the floors and walls of shower baths are scrubbed clean, and without evidence of slime or dirt (AR 30–1760).

(*r*) Wash bowls are clean, and with hot and cold water faucets working properly (AR 30–1760).

(*s*) Appropriate foot baths are provided near showers.

(*t*) Foot baths are properly cared for (Circular No. 47, W. D., 1938).

(2) *Guard house.*—(*a*) Sleeping rooms at the guard house are clean and well ventilated (AR 40–205).

(*b*) Heating system is adequate (AR 40–205).

(*c*) Suitable facilities are present at the guard house for bathing, toilets, and laundry (AR 30–1760).

(*d*) Beds of prisoners are in good condition and clean (AR 40–205).

(*e*) Their bedding is clean and sufficient (AR 40–205).

(*f*) Each prisoner has sheets, pillow slip, towel, and toilet articles (AR 600–375).

(*g*) Orders are in effect at the guard house to insure that bedding is aired at least once a week (AR 40–205).

(*h*) Beds used by sentries are clean (AR 40–205).

(*i*) What bedding they bring with them to guard house when reporting for guard duty.

(*j*) It is evident that the walls and the floors in the guard house have been scrubbed recently (AR 40–205).

(*k*) Beds of prisoners are grouped too closely, or tiers of bunks are placed less than 5 feet between side bars (AR 40–205).

(*l*) There is a minimum of at least 500 cubic feet of air space for each prisoner (AR 40–205).

(*m*) Prisoners who are placed in solitary confinement are allowed sufficient air space (AR 40–205).

(*n*) There is any evidence of vermin or of insects in the guard house (AR 40–205).

(*o*) If so, measures taken to exterminate them (AR 40–205).

(*p*) Any recommendations to improve sanitary conditions at the guard house (AR 40–205).

(3) *Mess halls and kitchens.*—(*a*) General sanitary condition of kitchens, mess halls, refrigerators, and store rooms (AR 40–205).

(*b*) Company kitchens and mess rooms are kept scrupulously clean at all times (AR 40–205).

(*c*) Mess rooms are tightly screened, and with screen doors that close automatically (AR 40–205).

(*d*) Any evidence of the presence of flies, roaches, or ants in the mess rooms (AR 40–205).

(4) *Bakeries.*—(*a*) Bakery is kept scrupulously clean at all times (AR 40–205).

(*b*) Men on duty in the bakery bathe frequently, wear clean clothing, and when practicable wear the white uniform (AR 40–205).

(*c*) These men are inspected frequently to see that before going on duty they have clean hands, with nails short and free from dirt, and that their clothing is clean (AR 40–205).

(*d*) Personnel on duty have been examined by a medical officer, certified as being free from communicable disease, and a list of such persons with the results of the examinations noted posted in the bakery (AR 40–205).

(*e*) Bakery is tightly screened and equipped with doors that close automatically (AR 40–205).

(*f*) Any evidence of the presence of flies, roaches, or ants in the bakery (AR 40-205).

(*g*) Flour, sugar, yeast, etc., are protected from dust (AR 40–205).

(*h*) Mixing boards, machines, and utensils are clean and free from dust or dirt (AR 40–205).

(*i*) Towels or other cloths are in use (AR 40–205).

(5) *Post exchange.*—(*a*) Post exchange is clean and operated and maintained in a sanitary manner (AR 40–205).

(*b*) Personnel on duty serving food, such as ice cream, milk, bottled goods, and other food stuffs, have been examined and certified by a medical officer as being free from communicable diseases (AR 40–205).

(*c*) List of permanent food handlers and certificates from a medical officer as to their being free from communicable diseases is posted in the exchange (AR 40–205).

(*d*) Ice cream containers, soda fountains, and other food containers are clean, free from corrosion or dirt, and kept tightly closed when not in use (AR 40–205).

(*e*) Facilities are available for the proper cleansing of glasses, spoons, and other utensils used in dispensing foods and drinks (AR 40–205).

(*f*) Candies, fruits, and other foodstuffs are protected from dust and insects (AR 40–205).

(*g*) Any recommendations to improve sanitary conditions at the post exchange (AR 40-205).

(*h*) Post exchange sells the individual prophylactic kit (AR 40–235 and circular letter No. 4, S. G. O., 1940).

(*i*) Prophylactic equipment sold by the post exchange is inspected and meets specifications (circular letter No. 4, S. G. O., 1940).

(6) *Barber shop.*—(*a*) All barbers on the post have read and they are complying with the provisions of paragraph 9, AR 40–205.

(*b*) Each barber is required to undergo a monthly physical inspection and such other tests as may be necessary to insure his freedom from communicable disease (AR 40–205).

(*c*) Barbers are required to keep their persons and clothing clean, and while attending patrons wear a clean, washable outercoat or uniform (AR 40–205).

(*d*) Wash their hands thoroughly with soap and water before attending each patron (AR 40–205).

(*e*) Barbers are prohibited from selling or giving away, without the written approval of the surgeon, medicinal preparations for the hair or skin, to be used outside the barber shop, or attempting, under any circumstances to treat pimples, warts, moles, or similar lesions of the skin or scalp (AR 40–205).

(*f*) Use of styptic pencils or lump or solid styptics is prohibited (AR 40–205).

(*g*) Interior of the barber shop is in a clean and sanitary condition (AR 40–205).

(*h*) Provisions have been made for an adequate supply of hot water and for the disposal of waste water (AR 40–205).

(*i*) Cuspidors are used and they are cleaned and disinfected daily (AR 40–205).

(*j*) A freshly laundered towel is used for each patron (AR 40–205).

(*k*) Head rest of barber chairs is provided with a sheet of paper or clean towel for each patron (AR 40–205).

(*l*) All brushes, combs, razors, clippers, shears, scissors, tweezers, buffers, massage and scalp appliances, etc., are cleaned, then sterilized after each separate use in an antiseptic solution such as 5-percent lysol for at least 3 minutes (AR 40–205).

(*m*) Use of powder puffs, sponges, and neck dusters is prohibited (AR 40–205).

(*n*) Use of shaving cups in common is prohibited (AR 40–205).

(*o*) A copy of paragraph 9, AR 40–205, is posted in each barber shop (AR 40–205).

(*p*) Any recommendations for sanitary improvement of barber shops (AR 40–205).

(7) *Commissary.*—(*a*) Commissary is kept scrupulously clean at all times (AR 40–205).

(*b*) See (4) (*c*) above.

(*c*) Permanent food handlers are examined by a medical officer, certified as free from communicable disease, and a list of such persons with the result of the examination posted (AR 40–205).

(*d*) Room used as a commissary is tightly screened, with doors that close automatically (AR 40–205).

(*e*) Any evidence of flies, roaches, or ants in the commissary (AR 40–205).

(*f*) All food is protected from dust (AR 40–205).

(*g*) Ice boxes and refrigerators are elevated to permit cleansing and inspection underneath (AR 40–205).

(*h*) Ice boxes are clean (AR 40–205).

(*i*) Counters, blocks, and utensils are clean and free from dirt or corrosion (AR 40–205).

(*j*) Any recommendations to improve the sanitary condition of the commissary (AR 40–205).

(8) *Meat market.*—(*a*) Meat market is clean and maintained in a sanitary condition (AR 40–205).

(*b*) See (4) (*c*) above.

(*c*) See (4) (*d*) above.

(*d*) Room used as a market is tightly screened and equipped with screen doors that close automatically (AR 40–205).

(*e*) Any evidence of the presence of flies, roaches, or ants (AR 40–205).

(*f*) All food is protected from dust (AR 40–205).

(*g*) Ice boxes and refrigerators are elevated at such height from the floor as permits cleaning and inspection underneath (AR 40–205).

(*h*) Ice boxes are scrupulously clean (AR 40–205).

(*i*) Knives are clean and free from accumulations of dirt (AR 40–205).

(*j*) Meat block and the counter are scrubbed clean (AR 40–205).

(*k*) Towels or other cloths are in use (AR 40–205).

(9) *Theater and service club.*—(*a*) Post theater and service club are well ventilated (AR 40–205).

(*b*) Both buildings are kept in a generally sanitary condition (AR 40–205).

(*c*) Constant attention is paid to the problem of keeping down dust in these buildings (AR 40–205).

(*d*) Toilets and toilet fixtures are clean and serviceable (AR 30–1760).

(*e*) Evidence of a common drinking glass being used in either building (AR 40–205).

(10) *Swimming pool.*—(*a*) Number and type of swimming pools in use (AR 40–275).

(*b*) Post orders are in effect govering the operation and sanitation of swimming pools (regulations for bathers and regulations and instructions for pool attendants) (AR 40–205 and Army Medical Bulletin No. 23).

(*c*) Surgeon furnishes the officer in charge of the swimming pool the names of all persons who are known to have an infectious disease, or who are known to be or are suspected of being carriers of infection in order that they may be prohibited from entering the pool enclosure (AR 40–205 and Army Medical Bulletin No. 23).

(*d*) Bathhouses are equipped with foot baths containing a solution of calcium hypochlorite so located that the bathers must use them when entering and leaving the shower baths (Army Medical Bulletin No. 23).

(*e*) Lay-out of entrances and exits of the pool in relation to dressing rooms, shower bathrooms, and toilets enforces the proper routing of the bathers so that coming from a dressing room a bather will be required to pass the toilets and go through the shower before arriving at the pool entrance. And bathers are required to leave the pool

through a separate exit leading to shower baths, toilets, and dressing room. If bathers reenter the pool after visiting the toilet they are required to pass through the shower bath (Army Medical Bulletin No. 23).

(*f*) Material used in the tank provides a tight tank with smooth and easily cleaned surfaces (Army Medical Bulletin No. 23).

(*g*) Pool is provided with an outlet at the deepest point of sufficient size to permit proper drainage (Army Medical Bulletin No. 23).

(*h*) Pool has all the desirable features noted below (Army Medical Bulletin No. 23):

1. Smooth surfacing.
2. Tank bottom with proper slope (1 foot to each 15 feet up to 6-foot depth mark).
3. Scum gutters.
4. Bottom and sides of pool lined with light or white material.
5. Proper marking to show depth.
6. Steps and ladders.
7. Runways.
8. Wholly enclosed by fence or wall.
9. A bathhouse with—
(a) Lockers.
(b) Dressing rooms.
(c) Toilet facilities.
(d) Shower baths.
(e) Office for attendants and for issue of bathing suits.
(f) Foot baths.
(g) Drinking fountain.
(h) Diving equipment.
(i) A recirculation system.
(j) Chlorination apparatus.
(k) Suction cleaner.

(*i*) Peak, or total bathing load (Army Medical Bulletin No. 23).

(*j*) Any remarks or recommendations to improve the sanitary conditions or operation of the swimming pool (AR 40–205).

(11) *Stable, picket line, and corral.*—(*a*) Stables are kept clean and dry at all times to abate the fly nuisance (AR 40–2080).

(*b*) Manure, soiled bedding, and refuse are removed daily and disposed of (AR 40–2080).

(*c*) Picket lines and corrals are policed and swept clean daily (AR 40–2080).

(*d*) Attention is paid to ground around watering troughs to see that it is kept clean and dry (AR 40–2080).

(*e*) Picket line is burned over or sprayed once a week in fly season (AR 40–2080).

(*f*) Fly traps and fly poisons are used around the stables in fly season (AR 40–2080).

(*g*) Any recommendations to improve sanitary conditions around the stables, picket lines, and corrals (AR 40–205 and AR 40–2080).

c. Water supply system.—(1) Any material change in the source of supply, methods of purification, potability, and adequacy of the water supply since date of the last December sanitary report (AR 40–275).

(2) Date and result of the last bacteriological test of the water supply (AR 40–205).

(3) Bacteriological tests of water are made monthly as required (AR 40–310).

(4) When last chemical test of the water was made (AR 40–310).

(5) Precautions as to collecting, shipping, and labeling of water specimens are observed (AR 40–310).

d. Disposal of garbage, manure, dead animals, and other refuse.—(1) Method used to dispose of garbage (AR 30–2175 and AR 40–205).

(2) Garbage collector is permitted to transfer garbage from can to can during collections at kitchens, thus creating a polluted condition of the soil (AR 40–205).

(3) Garbage cans are thoroughly sterilized or washed before being returned to the stand (AR 30–2175, AR 40–205, and ch. XVI, Army Medical Bulletin No. 23).

(4) Garbage cans are kept tightly covered and placed upon satisfactory stands (AR 40–205).

(5) Garbage is properly segregated (AR 30–2175 and AR 40–205).

(6) Post orders forbid the whitewashing of garbage cans (AR 40–205).

(7) Any recommendations to improve sanitary conditions at the garbage stands, along the route of transportation, or at the place of final disposal (AR 40–205).

(8) Method used to dispose of manure (AR 30–2175 and AR 40–205).

(9) Stable manure is removed daily to the place designated for its final disposal (AR 40–205).

(10) Any recommendations to improve the system of disposal of manure from a sanitary standpoint (AR 40–205, and ch. XVII, Army Medical Bulletin No. 23).

(11) Method used to dispose of dead animals (AR 30–2175).

(12) Method used to dispose of refuse such as sweepings, dirt, ashes, etc. (AR 30–2175).

e. Food supplies and their preparation.—(1) There is proper variety of food supplies available for messes (AR 40–205).

(2) Quality of the food supplies is good (AR 40–205).

(3) Food supplies are adequate (AR 40–275).

(4) Approved methods of dishwashing are used (AR 40–205).

(5) Milk sold on the post is of good quality (AR 40–2035).

(6) All milk sold on the post is pasteurized (AR 40–2035).

(7) If so, all pasteurization plants are fully up to standards (ch. XI, Army Medical Bulletin No. 23, and AR 40–2230).

(8) Raw milk is sold on the post (ch. XI, Army Medical Bulletin No. 23).

(9) All cows are tuberculin tested (AR 40–2230).

(10) All cows are given the agglutination test against abortion disease (ch. XI, Army Medical Bulletin No. 23).

(11) Milk is used on the post from cows giving a positive agglutination test (ch. XI, Army Medical Bulletin No. 23).

(12) Personal hygiene of permanent food handlers is maintained at a high standard (AR 40–205 and AR 40–2230).

(13) Permanent food handlers are examined regularly for evidence of any communicable disease (AR 40–205).

(14) Storage of food supplies is satisfactory (AR 40–205).

(15) Foods are prepared and served in a sanitary manner (AR 40–205).

(16) All meats, meat foods, and dairy products are inspected by a veterinary officer prior to delivery to the consumer (AR 40–205).

(17) Food supplies are protected against sun, heat, dust, insects, rodents, and other damaging or contaminating agencies (AR 40–205).

(18) A medical officer has inspected the food and drink establishments adjacent to the post which are frequented by members of the command (AR 40–205).

(19) Ice, bread, and fresh meat are issued daily when practicable (AR 40–205).

(20) Vehicles for transporting bread, fresh meat, and other exposed supplies are kept scrupulously clean (AR 40–205).

(21) Each organization or mess has clean paulins, cloths, or bags which will fully protect such exposed supplies from contamination by handling, exposure, or by contact with the vehicle (AR 40–205).

(22) Bread in transit is carried in covered basket, clean bed sacks, or similar devices to avoid contamination (AR 40–205).

(23) Company kitchens and mess rooms are kept scrupulously clean at all times (AR 40–205).

(24) Men on duty in the mess bathe frequently, wear clean clothing, and when practicable wear the white uniform (AR 40–205).

(25) Men on duty in the mess rooms are inspected frequently to see that before going on duty they have clean hands and that nails are free from dirt (AR 40–205).

(26) Permanent food handlers are reported by letter to the surgeon for examination and certification before being placed on such duty (AR 40–205).

(27) A list of such permanent food handlers with the results of the examination noted thereon is posted in the kitchen (AR 40–205).

(28) All food receptables, dishes, and table articles are protected from insects (AR 40–205).

(29) All food is protected from dust (AR 40–205).

(30) Ice boxes and refrigerators are elevated at such height above the floor as will permit cleaning and inspection underneath (AR 40–205).

(31) Ice boxes are kept scrupulously clean (AR 40–205).

(32) Dishes and utensils are washed with soap and hot water and rinsed with hot water after each meal (AR 40–205).

(33) Dish cloths are in use (AR 40–205).

(34) When fresh meats are received at a mess and sanitary defects are found, a medical officer is called at once (AR 40–205).

(35) Any recommendations to improve the food supply (AR 40–205).

f. Eradication of disease-bearing or other insects.—(1) Indigenous disease-transmitting insects and other insects that constitute a pest (mosquitoes, flies, fleas, etc.) prevalent (AR 40–275).

(2) Species of the important disease-bearing insects and those which cause discomfort found at the station (AR 40–275).

(3) In case that the species of such insects could not be determined specimens have been collected and sent to the Army Medical Museum for identification (AR 40–275 and AR 40–410).

(4) In what months these insects are most prevalent (AR 40–275).

(5) Measures used for their control (AR 40–205).

(6) Conditions on the post or adjacent thereto which favor the breeding of mosquitoes (AR 40–205).

(7) Measures taken or are recommended to be taken to abate or eliminate the conditions referred to above (AR 40–205).

(8) Unusual conditions on the post or adjacent thereto which favor the breeding of flies (AR 40–205).

(9) Measures taken or are recommended to be taken to eliminate or abate the conditions which promote the breeding of flies (AR 40–205).

g. Clothing.—(1) Issue of clothing is suitable for the prevailing climatic conditions (AR 40–275).

(2) Type of clothing issued has had any effect on the health of the command (AR 40–275).

3. General statistics, military personnel.—*a.* Enter the health statistics as noted in the table below:

	Year	Rate per 1,000 per annum for the command		
Admissions, all causes:				
Diseases only				
Injuries only				
Deaths, all causes:				
Diseases only				
Injuries only				
Admission, "new" venereal disease				
Prophylactic rate				

b. How marked variations in the table above can be accounted for (AR 40–275).

c. Give number of cases and annual admission rate per 1,000 for injuries produced by external causes other than wounds received in action for the past year (AR 40–1080).

4. Personal hygiene.—*a.* What the general health of the command has been during the past year (AR 40–275).

b. Any undue incidence of foot troubles or malformations during the past year (AR 40–275).

c. Commissioned officers witness the fitting of issue shoes and satisfy themselves that the feet of their men are kept in normal condition for marching (AR 40–205 and AR 850–125).

d. Quartermaster has established a suitable place where shoes may be fitted to men and records made and verified, and a try-on set, consisting of a complete series of each size and width, is furnished for issue (AR 850–125).

e. Last dental survey of the command indicates a large proportion of men who require dental attention (AR 40–510).

f. Sanitary order of the post prescribes that men will—

(1) Bathe at least once a week.

(2) Wash the hands before each meal and after visiting a latrine or toilet.

(3) Clean the teeth with a brush at least once a day.

(4) Keep the nails cut short and clean.

(5) Have the hair cut short.

(6) Keep their clothing and bedding clean.

(7) Keep soiled clothing in barracks bags (AR 40–205 and 40–275).

g. At the prescribed physical inspections the medical officer pays particular attention to the points mentioned above (AR 615–250).

h. Number of men discharged for disability during the past year (AR 40–275 and AR 615–360).

i. Discuss the reasons for such discharges for disability.

j. How many of such discharges were for causes of service origin.

k. How many causes existed prior to enlistment.

l. The command is completely protected by immunization against (AR 40–275)—

(1) Smallpox.

(2) Typhoid.

m. Any special immunization measures instituted during the past year (AR 40–275).

n. Record is kept to show that the command is protected against smallpox and typhoid fevers (AR 40–215).

o. Present dental classification of the command (AR 40–510).

5. Undue prevalence of acute communicable disease.—*a.* Any outbreaks of acute communicable disease at the station during the past year (AR 40–275).

b. Origin was determined (AR 40–275).

c. It was determined how the disease was disseminated (AR 40–275).

d. What the usual course of the epidemic was (AR 40–275).

e. Measures instituted for the control of the epidemic (AR 40–275).

6. New or improved administrative measures and sanitary appliances.—*a.* Sanitary appliances now in use in the command are satisfactory (AR 40–275).

b. Any new or improved types of sanitary appliances subjected to experimental use during the past year (AR 40–275).

c. If so, results obtained (AR 40–275).

d. Any such devices reported on during the past year. If so, give dates (AR 40–275).

APPENDIX II

CHECK LIST FOR COMMANDING OFFICER OR SURGEON

1. Hospital bed capacity (AR 40–1080).

Normal beds Emergency Expansion capacity

2. *a.* Buildings occupied for hospital purposes are satisfactory and of a capacity sufficient to meet normal needs (AR 40–585).

b. If the answer to *a* above is in the negative, detail what is required, stating the status of projects now authorized (AR 40–585).

c. A record is kept of repairs, alterations, and improvements to the hospital, showing nature of project, date approved by station surgeon, date completed, and total cost (AR 40–585).

d. Any of the floors in the hospital painted in violation of orders (AR 40–585).

e. Wooden steps and veranda and porch floors protected by paint (AR 40–585).

f. Instructions pertaining to construction and repair of hospitals are complied with (par. 16, circular letter No. 1, S. G. O., 1940).

3. *a.* Actual and authorized strength of the Medical Department personnel this date shown under the headings given below:

(1) Officers by name, grade, and corps.

(2) Army Nurse Corps by number.

(3) Enlisted men by grade and number.

(4) Civilian employees by designation and number.

b. Civilian employees are appointed, promoted, etc., in accordance with instructions in section VI, circular letter No. 1, S. G. O., 1940, and other references referred to therein.

4. Mean strength of the command this date (AR 40–275 and AR 40–1025).

Officers Army Nurse Corps Warrant officers
Enlisted Civilians

5. Commanding officer of the hospital has organized the professional and other activities of his hospital into services and prescribed their number, the lines of control over them, and their relationship to each other (AR 40–590).

6. What services and activities have been organized (AR 40–590).

7. What duties have not been delegated by the commanding officer to his assistants (AR 40–590).

8. *a.* There is an official Table of Organization for the medical detachment (AR 310–60).

b. There is a published letter showing the personnel authorized by grade and number (AR 310–60).

c. A graphic chart has been published showing the organization of the hospital and the duties of the personnel (AR 40–590).

d. Hospital regulations are complete and posted up to date (AR 40–590).

9. Current Table of Basic Allowances for the Medical Department is on file in the hospital (sec. III, AR 310–60).

10. Commanding officer has drawn up regulations for the hospital and caused them to be posted in appropriate places so as to be easily seen and read by those persons to whom they are applicable (AR 40–590).

11. Commanding officer has prepared a training schedule for medical personnel of the hospital, stating the objective or standards to be attained and the time available for the purpose.

12. Up-to-date files of the following publications are maintained (AR 310–10, AR 310–50, and FM 21–6):

a. Army Regulations.

b. Technical Manuals.

c. Field Manuals.

d. Field Service Regulations (FM 100–5 and FM 100–10).

e. Mobilization Regulations.

f. General Orders, Bulletins, and War Department Circulars.

g. Circular letters, Surgeon General's Office.

h. Orders, circulars, and memoranda of the corps area.

i. Orders, circulars, and memoranda of the post, camp, or station.

j. War Department training circulars.

13. System used to distribute orders, memoranda, information, etc., to officers on duty at the hospital.

14. Medical officers in their lectures on sex hygiene are instructed to warn all concerned of the dangers of self-medication with sulfanilamide (S. G. O. circular letters Nos. 13, 1938; 35 and 52, 1939; 17, 1940).

15. Mobilization plans for which the surgeon is responsible are up-to-date (MR).

16. How "secret," "confidential," and "restricted" documents and files are kept (AR 380–5).

17. *a.* Commanding officer of the hospital guards the knowledge of the combination of the hospital safe with the utmost care (AR 40–590).

b. Makes report by confidential letter direct to The Surgeon General of any changes in the combination of the hospital safe (AR 40–590 and AR 380–5).

c. When the combination was last changed (AR 40–590).

18. Decimal system of filing is in use at the hospital (War Department Correspondence File Book).

19. Precedent and policy file is maintained under Number 008 (War Department Correspondence File Book).

20. Retained copies of reports and returns, letters, etc., which are not useful in the transaction of current business, which are over 8 years old, have been reported to The Surgeon General within 1 year after the 8-year period has ended for disposition (AR 40–1005).

21. A Duty Roster, W. D., A. G. O. Form No. 6, is maintained for details of officer of the day, noncommissioned officer in charge of quarters, and emergency details (AR 345–25).

22. *a.* Duties of the medical officer of the day are clearly defined in hospital orders or regulations.

b. Hospital regulations require that the officer of the day will—

(1) Leave instructions where he may be found when away from the hospital.

(2) Make a written or verbal report to the commanding officer of his tour of duty.

(3) Make periodic inspections of the hospital and grounds.

(4) Take charge in case of fire until the arrival of the fire marshal.

(5) Inspect the guard and emergency details.

(6) Maintain good order and discipline.

(7) Enforce the hospital regulations.

(8) Be responsible for the verification and safeguarding of prisoner patients.

(9) See all operative cases of the day.

(10) Be responsible for the proper preparation of the body in case of death.

(11) Have prepared the Clinical Record, Brief, W. D., M. D. Form No. 55A, in all cases admitted to hospital.

(12) Inspect all ward order books to determine that treatment are being carried out (AR 40–590).

23. *a.* Commanding officer institutes proper measures for fire protection and prevention such as enforcing measures prescribed by

higher authority, the appointment of a fire marshal, the formulation of hospital fire regulations, periodic fire drill, inspections, etc. (AR 40–590).

b. Oil, paint, grease, gasoline, waste, and other inflammable materials kept in a separate building with adequate fire protection by the use of sand, chemical, etc. (AR 40–590 and AR 700–10).

c. Hospital fire regulations prescribe—

(1) Duties of individuals and groups.

(2) Place of assembly.

(3) Order of rescue and protection—

(*a*) Patients.

(*b*) Property.

(*c*) Records.

(*d*) Buildings.

d. How often fire drill has been held at the hospital (AR 40–590).

e. Fire escapes are in good condition and ample to clear the building quickly in case of fire (AR 40–590).

f. Helpless patients ever kept above the second floor of the hospital (AR 40–590).

24. Commanding officer inspects or directs the inspection of the entire hospital daily, and once each week inspects or causes to be inspected the medical detachment (AR 40–590).

25. There is a loose sheet binder containing the duplicates of sanitary reports (with official indorsements), and the duplicate Report Sheets of Sick and Wounded (W. D., M. D. Form No. 51) filed in single chronological sequence and permanently preserved as the medical history of the post (AR 40–1005).

26. Forwarding indorsements of the post commander and return indorsements of higher authorities have been transferred to the binder copy (AR 40–1005).

27. It is clearly understood by all concerned that information concerning the condition of sick patients necessary to allay the anxiety of friends will be freely imparted. Commanding officer has issued instructions in this matter (AR 40–590).

28. Commanding officer has issued instructions that will prevent the furnishing of information which can be made the basis of claims against the United States (AR 35–7020 and AR 345–415).

29. *a.* Whenever the condition of a patient reaches the stage which seriously endangers life, the Army chaplain on duty at the station is notified promptly (AR 40–590).

b. Chaplain makes regular visits to the men in confinement in the prison ward to give them advice and offer consolation (AR 60–5).

c. Chaplain makes regular visits to the sick in hospital for such spiritual and welfare ministrations as he may be able to give (AR 60–5).

d. Chaplain encourages correspondence between soldiers and their relatives and friends, especially on the part of the sick in hospital (AR 60–5).

e. If no Army chaplain is on duty at the station, the commanding officer, under AR 210–10, makes reasonable effort to provide religious guidance and services, especially for the seriously ill (AR 60–5).

30. A report is filed at the hospital of the fact of inspection of remains prior to interment or shipment (AR 40–590).

31. An alphabetical immunization file is maintained (AR 40–215).

32. Surgeon orders conducted a daily inspection of contacts when the first case of measles, mumps, diphtheria, scarlet fever, influenza, epidemic meningitis, etc., appears in an organization (AR 40–220).

33. Surgeon orders hospitalization of all cases of illness with catarrhal symptoms accompanied by a temperature of 100° F. or above (AR 40–220).

34. Surgeon is familiar with local civil laws in regard to quarantine, reporting births, deaths, and communicable diseases, etc. (AR 40–1080).

35. Surgeon directs the collection of mosquitoes during the mosquito season to determine the type of such insect prevalent at his station (AR 40–205).

36. It is clearly understood at the station that officers and enlisted men ordered to permanent detached service, or who are being transferred to a station where no dental officer is available, will report to the dental surgeon for treatment and inspection prior to departure (AR 40–510).

37. *a.* Commanding officer constantly supervises the mess and exercises every precaution to prevent waste and misuse (AR 40–590).

b. Uses the utmost care when assigning personnel to mess management to assign only those of known probity and good habits (AR 40–590).

c. By frequent inspections he sees that waste or wrongful diversion of supplies or funds is not permitted, and that the mess is so managed that neither patients nor duty personnel will have just grounds of complaint over the quality or quantity of their food (AR 40–590).

d. He inspects the Mess Account (W. D., M. D. Form No. 74) at frequent intervals so as to keep constantly informed on the status of the mess accounts (AR 40–590).

e. Officers on duty at the hospital are subsisted at the hospital mess (AR 40–590).

38. Any hospital property used for other than Medical Department purposes (AR 40–590).

39. Commanding officer causes an inventory of such articles of medical property as he may designate to be made from time to time by a disinterested Medical Department officer in order to assure himself that the inventory and stock record balances are in accord (AR 35–6520 and AR 40–1705).

40. Each administrative department or activity maintains a chart or index of the various regulations, orders, instructions, etc., pertaining to the administration of their respective department for ready reference purposes.

41. Clinical records show the date and hour of the patient's admission.

42. How long patients are in the hospital before a history and physical examination are made.

43. An impression of the patient's condition is entered on the clinical record at the time of taking history and physical examination.

44. What the longest interval is between notations on progress sheet of each clinical record.

45. Enumerate irregularities or discrepancies reported by the inspector general on his last inspection.

46. Irregularities or discrepancies reported by the inspector general have been corrected.

47. Civilian physicians in Army hospitals are authorized to sign official papers pertaining to military personnel (par. 8, circular letter No. 1, S. G. O., 1940).

APPENDIX III

CHECK LIST FOR REGISTRAR

1. Patient strength this date, classified as follows:

Officers	Nurses	Warrant Officers
Enlisted	U. S. Veterans Administration	Civilians

(AR 40–590 and AR 40–1005).

2. The active clinical records (W. D., M. D. Form No. 55 series) and the cards of the register of sick and wounded (W. D., M. D. Form No. 52) are filed in numerical sequence (AR 40–1025, FM 8–45).

3. *a.* A "current file" of register cards arranged in dictionary order is maintained (AR 40–1025, FM 8–45).

b. A "permanent file" of register cards by register number is maintained (AR 40–1025, FM 8–45).

c. Permanent file is unbroken, or cards of the past years have been transferred to an inactive file in numerical sequence (AR 40–1025, FM 8–45).

d. The register of sick and wounded, the file of clinical records, and the medical history of the post are permanently preserved (AR 40–1005).

e. Exactly where the files of inactive register cards and clinical records are stored (AR 40–1005).

f. Containers for inactive register cards and clinical records are marked properly with the contents, secure from dust and damage (AR 40–1005).

4. *a.* The reports of sick and wounded are always forwarded to the corps area surgeon on or before the 5th of the next succeeding month (AR 40–1025, FM 8–45).

b. What has prevented the reports of sick and wounded being mailed on the date specified (AR 40–1025, FM 8–45).

5. A register card (W. D., M. D. Form No. 52) and a clinical record brief (W. D., M. D. Form No. 55A) is started before the patient is admitted to a ward (AR 40–1025, FM 8–45).

6. *a.* A clinical record made up for serious cases treated in quarters (AR 40–1025, FM 8–45).

b. Clinical records are kept and reports rendered, as required, of all unusual or interesting clinical observations in connection with the use of sulfanilamide (S. G. O. circular letters No. 13, 1938, and No. 17, 1940).

7. A nominal card index of the sick is kept on W. D., M. D. Form No. 52a, one to each patient, and alphabetically and permanently filed (AR 40–1025, FM 8–45).

NOTE.—Check the last three admissions to see if the entry of register number was placed on the index card.

8. There is a "diagnosis index" of all diseases or injuries treated and all operations performed, recorded by the use of the numbers shown in AR 40–1025, FM 8–45.

9. A "disability index" is maintained for all cases discharged on certificate of disability (AR 40–1025, FM 8–45).

10. A "death index" is maintained for all cases that terminate in death (AR 40–1025, FM 8–45).

11. An "outpatient index" is maintained in two sections, the current and the general file (AR 40–1025, FM 8–45).

12. Births and deaths occurring at the station are reported to the Bureau of Census and civil authorities (AR 40–1080).

13. Statistical tables are prepared from the data on Statistical Report—First and Second Sections (W. D., M. D. Form No. 86ab) and kept current for—

a. Strength of command.

b. Annual mean noneffective rate.

c. Number of cases and annual admission rate per 1,000 for—

(1) All causes.

(2) Diseases only.

(3) Venereal diseases.

(4) Common respiratory diseases.

(5) Diarrheal diseases.

(6) Injuries produced by external causes other than wounds received in action.

(7) Such other diseases as conditions warrant or may be designated by higher authority.

(AR 40–1080).

14. Current graphic statistical charts are maintained on Vital Statistics Chart (W. D., M. D. Form No. 85), showing the current annual rate per 1,000 by weeks or months for the items listed in paragraph 13 (AR 40–1080).

15. Transfer of a patient from one ward to another at once is reported to the registrar (AR 40–590).

16. A "location index of patients" is kept in the registrar's office (AR 40–590).

17. *a.* Complete records of autopsies are kept at the hospital (AR 40–590).

b. Copies of all autopsy protocols are sent to the Curator, Army Medical Museum (AR 40–590).

c. How many deaths occurred during the past calendar year and what the percentage of autopsies was.

18. When a patient who has been formally or informally transferred to the hospital and discharged to duty, his commanding officer is notified by letter, through the surgeon of his station, giving this information:

a. The name of the patient.

b. The duration of stay in hospital.

c. Whether the illness or injury treated was incurred in line of duty.

d. Whether the illness or injury was due to the patient's own misconduct.

(AR 40–590).

19. The above rule is followed when a patient is transferred from hospital to quarters under the same circumstances (AR 40–590).

20. A follow-up file of cases discharged at the station because of disability is maintained in order that the report of discharge from the organization commander may be sent to The Surgeon General (AR 615–360).

21. Patients are informed by the admitting officer, or registrar, that the hospital will receive money or valuables for safekeeping and that the patient will receive a receipt signed by a commissioned officer (AR 40–590).

22. In the event that a patient is unconscious when admitted, the admitting officer searches the patient for money or valuables in the presence of a witness, and a receipt is given for the articles which are to be safeguarded (AR 40–590).

23. Money or jewelry invariably is deposited in a bank or in a safe, and other articles and papers in a locked compartment (AR 40–590).

24. Orders are in effect, and well understood, that enlisted men will never receive money or valuables for safekeeping (AR 40–590).

25. The registrar, as custodian of the patients' funds, keeps a book of receipt blanks with stubs, receipts and stubs numbered serially (AR 40–590).

26. Registrar gives each patient a receipt listing the money and valuables received from him for safekeeping, and he lists them on the corresponding stub which the patient signs indicating that the list is correct and shows all his money and valuables at the time of deposit (AR 40–590).

27. Custodian deposits all money in the hospital safe or in a local bank to the credit of "patients' fund" (AR 40–590).

28. Custodian keeps a patients' fund cash account wherein is debited all money received from and credited all money returned to patients (AR 40–590).

29. The above cash account is balanced at least once a month (AR 40–590).

30. Custodian of the patients' fund has a ledger, preferably a loose-leaf book, in which he keeps the individual account of the money and valuables of each patient, which account is balanced at least once a month (AR 40–590).

31. When a patient desires to withdraw money or valuables he is required to present his receipt on which the custodian notes on the back and on the stub the date and amount of withdrawal, requiring the patient to initial or sign both (AR 40–590).

32. In case of withdrawal of all the patient's deposits the custodian takes up the receipt and attaches it to the stub (AR 40–590).

33. The patient is required to initial the entries on the individual ledger when he withdraws money or valuables (AR 40–590).

34. Standing orders are in effect that in no case will money or valuables of a patient be turned over to an enlisted man for transmission (AR 40–590).

35. The patients' fund has been audited by an officer other than the custodian at the end of each month (AR 40–590).

36. Upon admission of a patient to the hospital his personal effects, other than money or valuables, are listed in duplicate on Patient's Property Card (W. D., M. D. Form No. 75) in his presence (or in the presence of a witness if the patient is unconscious or insane), signed by the patient (if conscious), bundled and tagged for identification, using Patient's Property Tag (W. D., M. D. Form No. 76), and properly and securely stored (AR 40–590).

37. The soiled clothing is always washed as a part of the hospital laundry before being stored (AR 40–590).

38. Whenever the death of a person occurs at the hospital an official report in writing is made to—

a. Station commander giving required information.

b. Corps area surgeon if the deceased is a Medical Department officer, Army nurse, or Medical Department enlisted man above the grade of sergeant, giving date, time, place, and cause of death.

c. The Surgeon General, a duplicate of the report in *b* above (AR 40–590).

39. When a patient has reached a stage which seriously endangers life, the person designated by the patient to be notified in case of emergency always is notified (AR 40–590).

40. *a.* The Surgeon's Morning Reports of Sick (W. D., M. D. Form No. 71) indicates that it has been made out each day, using one line for each separate company or detachment, and each column footed for each day opposite the word "TOTAL" in the column "company and regiment and corps," and signed each day by a medical officer on the line immediately below the total, using one line only for his signature and title (AR 40–1005).

b. The organization commander has entered each day in the proper column the strength of the command for the day, separately for officers and enlisted men, white and colored, Filipinos and Puerto Ricans (AR 40–1005).

41. How many cases have been recorded during the past month as follows:

Hospital	Quarters
Military	
All others	
Civilian	

(AR 40–1025 and FM 8–45).

42. The name, date of admission, diagnosis, and probable date of disposition of all cases now in hospital more than 2 months (AR 40–1025 and FM 8–45).

Name	Date of admission	Diagnosis	Probable Disposition

43. A Malarial Register (W. D., M. D. Form No. 56). See circular letter No. 63, S. G. O., 1941, for discontinuance of Malarial Register.

44. Any accumulation of obsolete, damaged, or unserviceable property on hand (AR 40–1705 and AR 700–10).

45. Registrar maintains a file of property held on W. D., M. D. Form No. 16b (AR 40–1705).

46. All medical property in the sick and wounded office has been examined and *verified* by a commissioned officer of the Medical Department within the last 6 months (AR 40–1705 and AR 35–6520).

47. Form No. 86c is rendered weekly for officer personnel only during periods of troop concentrations for training (par. 7, circular letter No. 1, S. G. O., 1940).

48. Clinical records furnished by the Medical Department to agencies other than The Adjutant General, are abstracted according to instructions (par. 9, circular letter No. 1, S. G. O., 1940).

49. Names and serial numbers of patients reported on sick and wounded cards are verified (par. 10, circular letter No. 1, S. G. O., 1940).

50. Syphilis cases are classified and reported (par. 10*d* and *e*, circular letter No. 1, S. G. O., 1940).

51. Injuries are reported and coded as required (par. 10*g* and *h*, circular letter No. 1, S. G. O., 1940).

52. Sick and wounded reports are prepared in accordance with instructions (par. 10, circular letter No. 1, S. G. O., 1940).

APPENDIX IV

CHECK LIST FOR MEDICAL SUPPLY OFFICER

1. Storerooms are clean, neatly arranged, and properly protected from fire, theft, and other damages (AR 700–10).

2. Who is intrusted with keys to the storerooms, closets, and lockers (AR 700–10 and AR 35–6520).

3. Personnel are adequate and well instructed in their duties (AR 40–590).

4. *a.* Standing orders are in effect prescribing the dates and manner of issues, the turning in, and exchange of medical supplies.

b. How often routine issues are made.

c. Issues are made at any hour of the day or night if a request is made (AR 40–590).

5. Any accumulation of obsolete, damaged, or unserviceable property on hand (AR 700–10).

6. Stocks of obsolete Medical Department blank forms are on hand (AR 40–1705 and AR 30–2145).

7. An accumulation of nonstandard supplies is on hand (circular letter No. 1, S. G. O., 1940).

8. A record of surplus property is kept (AR 40–1705).

9. Rotation of stocks is practiced; namely, containers for supplies which have been stored for some time are placed in front of new stock and issued first (AR 700–10).

10. *a.* A record is kept of the medical property issued to departments and individuals on W. D., M. D. Form No. 16b (AR 40–1705).

b. Any medical property issued to individuals and kept an undue length of time (AR 35–6520).

c. Any hospital equipment in use outside of the hospital for other than strictly professional purposes.

11. Date of the last complete physical inventory of medical supplies (AR 40–1705).

12. *a.* Any of the deteriorating medical supplies listed below stored in unit equipments as noted:

(1) Dental dispensary equipment (new pattern):

1 chest, MD No. 60 dental (95025).

Procaine epinephrine hypo tab.
Polisher, rubber cup.
Rubber, dam.

Syringe, water.
Rubber, red.
Basin, rubber.

(2) Regimental headquarters medical equipment (new pattern) (97646):

1 chest, MD No. 1 (99280).
Plaster, adhesive.
Apron, rubberized.
Basin, rubber.

1 chest, MD No. 2 (99281).
Digitalis hypo solution.
Procaine hydrochloride epinephrine.
Epinephrine soluble salt.
Apomorphine hydrochloride.
Ether.
Ethyl chloride.
Catheters, urethral (4).
Syringe, urethral, prophylaxis.
Tube, stomach.
Dropper, medicine.
Gloves, medium size.
Gloves, rubber, pouch for.
Plaster, adhesive.
Battery, dry cell.
Basin, rubber.
Bag, hot water, and syringe.

1 blanket, set, small (99098).
Blanket, rubber.

(3) Battalion medical equipment (new pattern) (97507). Same as (2) above.

(4) Veterinary dispensary equipment, small (new pattern) (97710):

1 chest, MD No. 80 veterinary (98070).
Ammonium carbonate lumps.
Chloral hydrate.
Apron, rubber.
Catheter, horse.
Tube, stomach.

1 chest, MD No. 81 veterinary (98080).
Battery, dry cell.

1 deck, field, company.
Bands, rubber.
Erasers.
Paste.

(5) Veterinary dispensary equipment, large (new pattern) (97703). Same as (4) above.

b. It is customary to keep any of the narcotics or alcohol listed below stored in unit equipment:

(1) Regimental headquarters medical equipment (new pattern) (97646):
Chest, MD No. 2 (99281).
Alcohol, ethyl.
Morphine.
Codeine.

(2) Battalion medical equipment (new pattern) (97507). Same as (1) above.

(3) Veterinary dispensary equipment, small (new pattern) 97710):
Chest, MD No. 80 veterinary (98070).
Alcohol, ethyl.

(4) Veterinary dispensary equipment large (new pattern) (97703). Same as (3) above.

c. Sufficient quantities of the above-mentioned deteriorating supplies and narcotics are kept on hand in the storeroom to stock completely the unit equipments of the combat organizations at the station.

d. List of the above items is kept in the equipment chests to avoid danger of delay or shortage when a unit takes the field.

13. The medical supply officer experienced any difficulty in securing the kinds and quantities of medical supplies required since the date of last inspection (AR 40–1705 and circular letter No. 1, S. G. O., 1940).

14. *a.* The money allowance for expendable medical supplies has been sufficient to cover the needs of the hospital during the past year (circular letter No. 1, S. G. O., 1940).

b. Every item of expendable supplies that is placed on requisition is carefully scrutinized to see if any item—

(1) Is in excess of current needs.

(2) Can be dispensed with (items should not be requested simply because they are listed in the Medical Department Supply Catalog).

c. How many emergency requisitions have been submitted during the past 12 months (AR 40–1705).

15. Smallpox vaccine is invariably stored in a refrigerator in direct contact with ice, or in the freezing unit of a mechanical refrigerator (AR 40–215).

16. Time limitation of any stock of vaccines or serums has expired (AR 40–215).

17. *a.* Vaccines and serums now on hand. When vaccines are supplied in bottles, time-expired stocks are returned to the Army Medical School, unless otherwise indicated. Empty bottles also returned (AR 40–215).

b. Utmost care is taken by all concerned to prevent accumulation of excess stocks of biologicals.

c. Biologicals on hand are less than 1 year old. In the case of NS antipneumococcic sera, 6 months.

d. Records show excessive exchange of biologicals (par. 64, circular letter No. 1, S. G. O., 1940).

18. The Medical Department Supply Catalog is posted up to date, to include all changes in nomenclature, prices, etc.

19. The medical supply officer has a file of—

a. Circular letter No. 1, S. G. O., 1940, and those listed in paragraph 39 of this circular letter.

b. Army Regulations pertaining to finance and supply.

c. Procurement Circulars.

d. Extracts from Army Medical Bulletins pertaining to finance and supply; copies of pertinent decisions of the S. G. O. etc., properly bound and indexed for reference purposes (POLICY FILE).

20. Separate meters are installed to record the electric current used for X-ray machines, centrifuges, and other such purposes.

21. W. D., M. D. Form No. 16a, is used to request supplies for pharmacy, wards, etc.

22. The following forms invariably are used to request, return, and exchange nonexpendable property:

a. Issue Slip, Nonexpendable Medical Property (W. D., M. D. Form No. 16b).

b. Credit Slip, Nonexpendable Medical Property (W. D., M. D. Form No. 16c).

c. Exchange Slip, Nonexpendable Medical Property (W. D., M. D. Form No. 16d).

23. The medical supply officer retains the originals of W. D., M. D. Forms Nos. 16b, 16c, and 16d to file with the Memorandum Receipts (W. D., Q. M. C. Form No. 487) (AR 40–1705).

24. Date of the last inspection of organizational equipment, field chests, and other field equipment (AR 40–1705).

25. A journal is maintained to show the monthly totals of the value of receipts of medical supplies and of expenditures, as required (AR 40–1705).

26. The medical property of which the several officers are responsible has been examined every 6 months by a commissioned officer of the Medical Department and by him verified by stock record cards, receiving reports, shipping tickets, etc. (AR 40–1705 and AR 35–6520).

27. Complete and serviceable field equipment and supplies are on hand for each unit in the garrison according to Tables of Basic Allowances and Tables of Allowances of the Medical Department as modified (AR 310–60).

28. A record is maintained in the storeroom of receipts and expenditures of alcohol, alcoholic liquors, opium, and the salts, derivatives, and preparations of opium and coca leaves in the manner prescribed for the pharmacy (AR 40–1705 and AR 40–590).

29. *a.* Balances of alcohol and narcotics are correct (AR 40–590).

b. In whose possession the keys to the alcohol and narcotic room are kept. Anyone else have possession of these keys at any time (AR 700–10 and AR 35–6520).

30. Entries on the return of medical property slip (W. D., M. D. Form No. 17a) are correct for each of the drugs noted below, since date of last inspection:

10480 Alcohol, ethyl, 1 qt. USP.
10490 Alcohol, ethyl, 5 gal. USP.
10500 Alcohol, dehydrated, 1 pt. USP.
11450 Cocaine, hydrochloride, ¼ oz. USP.
11480 Codeine, sulfate, 1 oz. USP.
11490 Codeine, sulfate, ½-grain tablet, 500, USP.
12940 Morphine, sulfate, 1 oz. USP.
12950 Morphine, sulfate, ⅛-grain hypo tablets, 20, USP.
12955 Morphine, sulfate, ¼-grain hypo tablets, 10, USP.
12960 Morphine, sulfate, 2-grain hypo tablets, 10, USP.
13230 Opium, 1 oz. powder, USP.
14850 Tincture, opium, ¼ pt. USP.
14860 Tincture, opium, camphorated, 1 pt. USP.
14940 Whisky, 1 qt. USP.
14945 Wine, sherry, 1 qt.
Nonstandard items corresponding to the above.

(AR 40-590.)

31. The medical supply officer is familiar with instruction regarding the shipment of containers for alcolohic liquors (sec. V, AR 30–955 and AR 40–1705).

32. Alcohols, alcoholic liquors, opium, and the derivatives of coca leaves are issued only to the pharmacy and in unit containers, only on the written order of a medical officer (AR 40–1705).

33. Blankets in storage are protected from moths (AR 40–1705).

34. Rubber goods are properly protected by the use of talc, etc.

35. Before submitting his requisition the medical supply officer obtains from each chief of service or department a list of the supplies required by his department for the period covered by the requisition (AR 40–1705).

36. A record is kept of each Medical Department typewriter on hand showing—

a. Make of machine.
b. Model number.
c. Serial number.
d. Width of carriage.
e. Date placed in service.
f. Total expenditures for repairs.
(AR 40–1705.)

37. *a.* Medical supply officer is required to maintain an inspection and servicing card for all Medical Department equipment having storage batteries or moving parts requiring oiling such as—

51740 Compressor unit.
72770 Dishwasher, electric.
72775 Dishwasher, electric.
72835 Extractor, juice, orange and lemon.
73260 Mixer.
73460 Peeler, vegetable.
73470 Peeler, vegetable.
73980 Slicer, meat.
74940 Sweeper, carpet, electric.
74834 Polisher, floor.
78045 Fountain, drinking.
78515 Machine, sewing.
79170 Sterilizers, electric.
78180 Sterilizers, electric, etc.

b. These charts show—

(1) Item number and name, or name only of item, if nonstandard.
(2) Location of item.
(3) Date of issue.
(4) Service to be rendered, and remarks (under remarks state any peculiarity of item and service to be rendered).
(5) Periodic inspections (date).
(6) Date, nature, and cost of each repair or replacement of parts.

c. A duplicate card has been furnished the service man.

d. All such items are inspected and serviced at least once each month.

e. A record is kept of each Medical Department refrigerator on hand showing—

(1) Make and capacity in cubic feet.
(2) Date of receipt.
(3) Location.
(4) Date, nature, and cost of each repair.
(5) Time out of service.
(AR 40–1705.)

f. Electric refrigerators having adjustments which permit regulation of the temperatures should not be adjusted to the lowest temperature. (This results in almost continued operation of the motor and unit and will cause excess cost for repairs.)

38. The medical supply officer maintains a list showing where emergency purchases of vaccines and serums can be made.

39. Hospital laundry is put out to private laundries on contract or informal agreement (AR 40–590).

40. What the cost of laundry was for each month of the last 6 months (AR 40–590).

41. What the cost of laundry is per patient day.

42. Average number of pieces of laundry used per patient during the last 12 months is greater than six per patient per day.

43. Sphygmomanometers (other than mercurial) are tested at frequent intervals and steps taken to have them corrected (AR 40–1705).

44. *a.* An accession book for medical library books is maintained (AR 35–6800).

b. There is an accumulation of obsolete or damaged medical books (AR 40–1705).

45. *a.* It has been necessary to purchase ice from the quartermaster for the preservation of foodstuffs during the past 12 months.

b. Payment was made from the hospital fund (AR 40–590).

46. How ice is procured for such uses as ice packs, medical photographic work, and the preservation of biologicals (AR 40–590).

47. Plans have been submitted to provide an approved storeroom for X-ray films.

48. *a.* Wiring in the present storage space for X-ray films conforms to the N. E. A. code.

b. Only guarded incandescent lamps are permitted in the X-ray storage room.

c. Extension lamp cords are used.

d. "NO SMOKING" signs are posted.

e. Film is removed at least 2 feet from steam pipes, radiators, chimneys, or other sources of heat.

f. Chemical fire extinguishers (not using carbon tetrachloride) are provided.

g. Negatives in storage are kept in heavy manila envelopes or in cardboard boxes, not exceeding six films to the envelope or 25 to a box.

h. X-ray storage room is not used for any other purpose.

i. X-ray storage room is in the hospital or in a separate building (circular letter No. 1, S. G. O., 1930).

j. Disposition made of used X-ray films (circular letter No. 14, S. G. O., 1936).

49. There is a conservation of micro slides, cover slips, and other supplies (circular letter No. 32, S. G. O., 1940).

50. Supplies are stored on shelves in the same order as they appear on the supply tables (AR 700–10).

51. Provisions of section V, paragraphs 39 to 77, inclusive, circular letter No. 1, S. G. O., 1940, pertaining to finance and supply are being complied with.

APPENDIX V

CHECK LIST FOR DIRECTOR OF DIETETICS (MESS OFFICER)

1. *a.* Organization of the mess force (AR 40–590).

b. Mess personnel are sufficient and well qualified (AR 40–590).

c. There is a certificate posted in the kitchen that each permanent food handler has been examined by a medical officer and is free from communicable disease (AR 40–205).

d. Cooks and mess attendants always wear white uniform and cap while on duty and keep their hair cut short, nails short and clean, and their person clean (AR 40–205).

e. Number of cooks (AR 310–60).

f. Ratings held by cooks (AR 310–60 and AR 615–20).

g. Cooks clean and efficient (AR 40–205 and AR 615–20).

h. Gratuities paid to cooks or other mess attendants (AR 210–50).

2. *a.* Any hospital property used for other than Medical Department purposes. If so, specify. (AR 40–590).

b. All property is protected from danger from theft, fire, and other damage (AR 40–590).

c. Any accumulation of obsolete, damaged, or unserviceable property is on hand (AR 40–1705 and AR 700–10).

d. Any property or supplies on hand not required for current use (AR 40–1705).

e. Mess officer maintains a file of property held on Memorandum Receipt (W. D., Q. M. C. Form No. 487) (AR 40–1705).

f. Mess supplies and equipment are adequate and satisfactory (AR 40–1705, Medical Department Supply Catalog, and circular letter No. 1, S. G. O., 1940).

g. All medical property in the mess has been examined and *verified* by a commissioned officer of the Medical Department within the last 6 months (AR 40–1705 and AR 35–6520).

h. Containers for poisons such as rat poisons, roach powders, etc. are kept in the mess room (AR 40–590).

3. *a.* Average number of duty status men to be fed daily (section V, AR 345–400).

b. Average number of patients who eat in the mess hall daily (AR 40–1005).

c. Average number of patients who receive their food in the wards daily (AR 40–1005).

d. At what hour the mess officer receives notification of daily patient strength, showing the subsistence classification of patients (AR 40–590).

4. *a.* Diet kitchens have been established by the commanding officer (AR 40–590).

b. Rules for its management have been prescribed by the commanding officer (AR 40–590).

c. Bills of fare for diets prescribed by or under the supervision of the commanding officer have been made out and posted in the kitchens (AR 40–590).

d. Diet Cards (W. D., M. D. Form No. 73) are filled out by each ward officer daily, immediately after he has made his first visit to the ward and covering the requirements of the ward patients for the ensuing 24 hours (AR 40–590).

e. Additional cards for newly admitted patients are made out promptly and sent to the mess officer without delay (AR 40–590).

f. Facilities for serving and sending meals to ward patients are adequate (AR 40–590).

g. Food intended to be served hot is always delivered to the patient in that condition (TM 10–405).

5. *a.* From what sources moneys are received which are credited to the hospital fund at this station (AR 210–50).

b. What the monthly balances have been each month during the past 12 months (AR 210–50).

c. Payments made from the hospital fund for any of the following items:

(1) Electric time clock service.

(2) Personal telephone service.

(3) Cooking utensils.

(4) Ice or electricity for Medical Department use. (AR 210–50, decision of S. G. O., and circular letter No. 1, S. G. O., 1940).

d. Hospital fund council audits the fund, examines receipts and expenditures, and makes recommendations as to the policies under which the fund is to operate (AR 210–50).

e. Charges are made as noted below for patients not entitled to commutation of rations (AR 40–590):

(1) Officers and warrant officers at $1.00 per day.

(2) Officers and warrant officers of the Navy at $1.00 per day.

(3) Civilians on the status of officers at $1.25 per day.

(4) Army nurses at $1.00 per day.

(5) Enlisted men of the Navy and retired enlisted men of the Army an amount equal to the commuted rate.

(6) Civilians on the status of enlisted men an amount per day equal to the commuted rate plus $0.10 per day.

f. It has been necessary to report to The Surgeon General any cases of unpaid subsistence accounts of patients during the last 12 months (AR 40–590).

g. Accounts for the hospitalization of personnel of the Navy, Marine Corps, U. S. Public Health Service, the Coast and Geodetic Survey, and the Coast Guard, who are entitled to treatment at Government expense, are mailed so as to reach The Surgeon General's Office not later than the 15th of the month following discharge from hospital (retired Naval and Marine Corps personnel excepted) (par. 69, circular letter No. 1, S. G. O., 1940).

h. Amount of subsistence accounts now due and overdue. List separately (AR 40–590).

i. Who receives and handles subsistence moneys for the mess account (AR 40–590).

j. All funds received for the subsistence of patients are placed in the hospital fund (AR 40–590).

k. Any unserviceable durable property purchased from the hospital fund now on hand. If so, itemize (AR 210–50, and instructions on W. D., M. D. Form No. 49).

l. What the amount is of the usual dividends received from the post exchange (AR 210–65).

6. *a.* Mess account (W. D., M. D. Form No. 74) is kept up to date from day to day (AR 40–590).

b. Enumerate the sources from which foods and mess supplies have been purchased during the last completed month (AR 210–50).

c. A stock record card or other system is used to account for supplies received and issued (AR 40–590).

d. Who makes purchases and orders the mess supplies (AR 40–590).

e. Every delivery of supplies to the mess is scrutinized as to amount and quality (AR 40–590).

f. Food storerooms are guarded by lock and key, bars and gratings (AR 40–590).

g. To whom the keys of the storeroom are intrusted (AR 40–590).

7. *a.* Mess rooms, kitchen, pantries, and storerooms are clean and well arranged (AR 40–205).

b. What system is in use to insure that the mess officer knows that certain dishes and utensils have been used by patients with communicable diseases in order that such dishes will not be stored or used before being sterilized (AR 40–590).

c. Venereal patients are fed at separate tables and from separate dishes (AR 40–245).

d. Meat is suspended in the refrigerator in such manner that it cannot touch walls, partitions, or other material to avoid the formation of mold (AR 40–205).

e. Meat and dairy products are inspected by a veterinary officer when delivered (AR 40–205).

8. See paragraph 2*d*(1) to (7), inclusive, appendix I.

9. *a.* Mess officer has copies of TM 10–405.

b. TM 10–405 is used as a guide in the preparation and serving of foods (AR 40–590).

10. *a.* Menus are so arranged that a diet is supplied that will contain balanced and adequate amounts of protein, fat, carbohydrates, vitamins, and mineral salts (AR 40–205).

b. Weekly menus are so varied that no essential article of diet is ignored because of faulty preparation or too continuous or frequent use (ch. VIII, Army Medical Bulletin No. 23).

c. How often the following foods are served (AR 40–590 and TM 10–405):

(1) Butter.
(2) Fresh milk.
(3) Desserts.
(4) Fresh fruits.
(5) Fresh vegetables.
(6) Bread puddings.
(7) Meat.
(8) Bologna.

d. What variety of breadstuff is served (TM 10–405).

11. Garbage cans are inspected regularly to detect any evidence of wastage (AR 40–590).

12. *a.* What the hours are for each meal.

b. A check is made by the mess officer to see that each meal is served exactly on time.

c. More than one sitting at any meal.

d. How many men eat at the second sitting.

e. How many men eat at the first sitting.

f. What the time interval is between the two sittings (AR 40–590).

13. Hospital fund is managed in accordance with special instructions of The Surgeon General (par. 15, circular letter No. 1, S. G. O., 1940).

APPENDIX VI

CHECK LIST FOR COMMANDING OFFICER, MEDICAL DETACHMENT

1. *a.* How many enlisted men this date are on—
(1) Furlough.
(2) Pass.
(3) AWOL.
(4) DS.
(5) Special duty (specify).
(6) Restriction.
(7) In confinement.
(8) Other nonduty status.

b. If any men are awaiting trial any delay in the matter (AW 70).

c. How many enlisted men of the detachment have been tried by courts martial during the past 12 months.

General court martial_____
Special court martial_____
Summary court martial_____
Total_____

d. How many of the enlisted men of the detachment have been awarded company punishment under the 104th Article of War during the past 12 months.

2. Attach a roster of the detachment showing individuals by—
a. Department, such as X-ray, mess, etc.,
b. Grades and ratings.
(AR 40–590, AR 345–55, and AR 345–900).

3. Records of medical personnel are handled at the hospital by the commanding officer, medical detachment, or by unit personnel section.

4. Complete records of immunization are entered in the service records (AR 40–215 and AR 345–125).

5. *a.* Record is made in each service record when the course of sex morality is completed (AR 40–235 and AR 345–125).

b. Enlisted men of the detachment have been informed that death or disability resulting from the unauthorized use of sulfanilamide in the treatment of venereal disease are considered not in line of duty (S. G. O., circular letters Nos. 13, 1938, and 17, 1940).

6. Notation appears in each service record that certain Articles of War have been read and explained within 6 months (AW 110 and AR 345–125).

7. Record of company punishments is kept in a separate account (AR 345–125).

8. Record is made of the size of shoes worn by each enlisted man (AR 850–125).

9. Commanding officer, medical detachment, has secured a supply of the necessary blank forms for application for pension; familiarized himself with the pension law, and offered to execute a pension application for each enlisted man discharged on certificate of disability (AR 615–360).

10. Daily sick report is sent to the detachment commander as soon as possible after an entry of "No; AR 35–1440" has been made in order that he may make a provisional notation on the pay rolls and on the service record of the patient and affix his initials in the column "Date" on the sick report opposite the name of the soldier in the first entry in which the notation "No; AR 35–1440" appears (AR 345–415).

11. In case of enlisted men carried on sick report with an entry of "No; AR 35–1440" and after final action has been taken, the detachment commander makes the necessary entries on the pay rolls and on the service record of the patient, and affixes his initials in the "Date" column on the sick report opposite the name of the patient in the last entry in which the notation "No; AR 35–1440" appears (AR 345–415).

12. Use of TM 8–220 for instructions and reference purposes is encouraged.

13. The detachment as a whole has completed its basic military training to include—

a. Basic disciplinary training of a soldier.
b. Physical training, personal hygiene, and first aid.
c. Interior economy and administration.
d. Shelter, supply, and movement.
e. Security.
f. Signal communication.
g. Protective measures against chemical agents.
h. Expert care of equipment and transport.
i. Tactics and technique of the Medical Department.
j. Cooperative duties as part of the combat train (MTP 8–1).

14. Detachment commander has prepared training plans for the training of the unit, either a training program or a training schedule.

15. Every man in the detachment has completed a course of instruction to the degree that he is proficient in—

a. Knowledge of Articles of War pertaining to enlisted men.
b. Knowledge of Army Regulations pertaining to enlisted men.

c. Knowledge of local orders pertaining to enlisted men.
d. Military courtesy and customs of the service.
e. Knowledge of uniform regulations pertaining to enlisted men.
f. Personal hygiene and sanitation.

16. *a.* A troop school is maintained as a function of command for all members of the detachment (AR 350–5).

b. How many men during the past year have been issued a certificate of proficiency in subjects covered in the troop school program (AR 350–5 and AR 40–1005).

17. *a.* Every member of the detachment has attended one course of instruction in sex hygiene (AR 40–235).

b. Instruction in sex hygiene and the prevention and control of venereal disease is given to all enlisted men at least twice each year (AR 40–235).

18. Facilities provided on the post in general, and in the hospital in particular, for the recreation of the detachment (AR 210–50).

19. A commissioned officer superintends the fitting of issue shoes by the shoe-fitting apparatus (AR 40–205 and AR 850–125).

20. Members of the detachment have been typed as blood donors and a list maintained of individuals who are available as donors (AR 40–1715).

21. All men of the detachment are capable of rendering first aid in the post and in the field (FM 21–10).

22. Enlisted men are permitted to use Medical Department linens, supplies, equipment, or appliances in their rooms or on their person (AR 40–590).

23. Enlisted men are permitted to wear the white uniform when not actually engaged in an appropriate duty in the hospital (AR 600–40).

24. Copies of hospital regulations are posted in conspicuous places for the information and guidance of members of the detachment (AR 40–590).

25. What the new case rate is per 1,000 per annum for venereal disease for each month of the preceding 12 months for the detachment (AR 40–235).

26. *a.* There is at least 60 square feet of floor space and 720 cubic feet of air space for each man occupying a bed in the squad rooms.

b. If not, is head and foot sleeping practiced (AR 40–205).

27. White uniforms of the enlisted attendants are laundered as a part of the hospital laundry (AR 40–590).

28. Garrison shoes with rubber heels are furnished men on duty in wards and departments of the hospital.

29. Prescribed Articles of War are read and explained within 6 days after enlistment or reenlistment and once each 6 months thereafter (AW 110).

30. Every enlisted man of the detachment is inspected by a medical officer each month. Noncommissioned officers of the first three grades may be excused (AR 615–250).

31. In addition to the monthly physical inspection noted above, the commanding officer occasionally orders a special venereal inspection upon recommendation of the surgeon of all enlisted men, except noncommissioned officers of the first three grades and married men of good character for the purpose of detecting cases of venereal diseases (AR 615–250).

32. Any complaints in regard to the detachment mess (AR 40–590).

33. *a.* Each man's bed and wall locker are properly marked for identification (AR 40–590).

b. Personal equipment is properly displayed on the end iron of the bunk (AR 40–590).

c. Soiled clothing is kept only in the barracks bag (AR 40–205).

d. Sketches are posted in conspicuous places showing how equipment should be displayed for inspection (FM 21–15 and FM 21–100).

e. Any types of insects prevalent in the squad rooms (AR 40–205).

34. *a.* Men on night duty are sleeping in a secluded, quiet place.

b. A check is made to determine that night men get proper sleep during the daytime.

35. Administration of the medical detachment is in conformity with the general provisions of AR 245–5 insofar as applicable.

36. Detachment storerooms are clean, neatly arranged, and individual equipment properly stored and tagged.

APPENDIX VII

CHECK LIST FOR PRINCIPAL CHIEF NURSE

1. Grade and number of nurses on duty at the hospital (AR 40–20).

2. Principal chief nurse acts directly under the immediate orders of the commanding officer of the hospital in regard to all matters pertaining to the general supervision of the nursing service and to the nurses' quarters (AR 40–20).

3. Commanding officer refers all official correspondence relating to the nurse personnel to the principal chief nurse for notation or recommendation (AR 40–20).

4. Principal chief nurse familiarizes herself with Army Regulations insofar as they relate to the Army Nurse Corps, and instructs the nurses under her supervision in the regulations pertaining to them, and in their duties peculiar to Army work, and when necessary in all matters pertaining to their nursing work (AR 40–20).

5. Commanding officer has required the principal chief nurse to supervise the instruction of enlisted men of the Medical Department on ward duty in practical nursing (AR 40–20).

6. Principal chief nurse prepares the records, reports, returns, etc., concerning nurses, and indorses or initials all official papers submitted in connection with the nurses and requiring the signature of the medical officer in command (AR 40–20).

7. She sees that nurses properly perform their duties and makes herself responsible for the maintenance of discipline among them, both while on duty and in quarters (AR 40–20).

8. She arranges the hours of duty, rest periods, and assignments of all nurses, arranges for the comfort and general well-being of the nurses under her charge, and reports to the commanding officer any matters which injuriously affect the same (AR 40–20).

9. Principal chief nurse assigns a nurse to supervise the nursing service of the hospital at night, and to report to the principal chief nurse upon relief any unusual incidents of the night's work and any deredictions of duty on the part of the night nurses (AR 40–20).

10. Principal chief nurse designates one nurse for each ward to act as its responsible head under the following regulations:

a. To be in charge of the ward, the nurses, the enlisted personnel, and other persons assisting in the nursing care of patients, and of the patients, under the direction of the ward officer.

b. To receive from the ward officer all orders relating to the care and treatment of the patients in the ward, and to record the orders for the guidance of both day nurses and night nurses.

c. To be responsible for the proper nursing of the patients, the proper serving of all food in the ward, the administration of medicines and other treatment prescribed, the cleanliness and order of the ward, the safety of the effects of the patients until they have been turned over to the proper custodian, the prompt transmittal of prescriptions to the pharmacy, and the prompt delivery of the diet orders to the mess office (AR 40–20).

11. Nurses are required to perform duties the same as in civilian hospitals of like general character, with a day's work not to exceed 8 hours; and are not required, except in an emergency, to serve on night duty oftener than 1 month in every 3 months (AR 40–20).

12. Nurses' quarters provide one dining room, one kitchen, one sitting room, and the necessary toilet rooms for the common use of all nurses, and a separate bedroom for each nurse; and, if more than five nurses are on duty, an office and a separate sitting room for the principal chief nurse (AR 40–20).

13. Suitable furniture and care for the nurses' quarters are provided (AR 40–20).

14. Sheets, towels, pillowcases, table linens, and other washable articles are laundered as a part of the hospital linen (AR 40–20).

15. Suitable meals and proper messing facilities, including necessary equipment, and service for nurses on duty are provided (AR 40–20).

16. Each nurse, promptly at the end of each month, or when departing from the station on transfer, leave of absence, etc., pays into the hospital fund a designated amount for credit to the nurses' mess, for each day she has been furnished meals therein, the amount prescribed in AR 40–20.

17. Any accumulation of supplies or equipment on hand in the nurses' quarters in excess of present requirements (AR 40–1705).

18. Any obsolete, damaged, or unserviceable supplies or equipment on hand (AR 40–1705 and AR 700–10).

19. It is possible to grant annual leave to the nurses without crippling the service.

20. Principal chief nurse maintains a record of nonexpendable supplies on W. D., M. D. Form No. 16b (AR 40–1705).

21. Expenditures from the hospital fund are made for furnishings for nurses' recreation rooms or for other purposes (AR 210–50, and par. 15, circular letter No. 1, S. G. O., 1940).

22. What system is used to insure that the nurses receive due credit for funds turned in by them to the hospital fund from all sources (commutation of rations, donations accruing from their guests, messing charges for aides, technicians, and other civilians authorized to subsist at the nurses' mess) (par. 15, circular letter No. 1, S. G. O., 1940).

23. Any of the above credits used to provide means for contributing to the welfare, comfort, pleasure, contentment, and mental and physical improvement of members of the nurses' mess. If so, whether such expenditures exceed their credits (par. 15, circular letter No. 1, S. G. O., 1940).

24. Principal chief nurse maintains a council book to account for moneys received from miscellaneous sources in violation of existing regulations (par. 15, circular letter No. 1, S. G. O., 1940).

APPENDIX VIII

CHECK LIST FOR CHIEF OF SURGICAL SERVICE

1. General.—*a.* Organization of the surgical service (AR 40–590).

b. How often a complete inspection of entire service is made by chief of surgical service.

c. How often professional conferences are held.

d. How transfers of patients from one ward to another ward are handled (AR 40-590).

e. Copies of hospital rules are posted in convenient places where they may be seen by patients and duty personnel.

2. Genito-urinary section.—*a.* (1) A syphilitic register is on file at the hospital for every militarized person of the command who has syphilis.

(2) Complete entries have been made under the following headings:

(*a*) Date and place of infection.

(*b*) Source of infection.

(*c*) Prophylaxis.

(*d*) Date of appearance and exact location of primary lesions.

(*e*) Incubation period.

(*f*) Other lesions.

(*g*) Complicating venereal diseases.

(*h*) Dark field examinations.

(3) Certificate has been signed by the patient acknowledging that he has been informed of the nature of syphilis and that he is convinced that he has syphilis, etc.

(4) Data as to "general physical examination and pertinent facts of past history" have been fully recorded.

(5) Comments as to the progress of the disease and record of later physical examinations appear under "later physical examinations and progress of case".

(6) Blood serum reactions have been recorded as double plus, plus, plus-minus, and minus (or negative).

(7) Entries have been made to cover all therapeutic measures taken.

(8) Every entry has been signed where indicated by a medical officer.

(9) In the case of registered personnel being transferred the register has been forwarded to the surgeon of the new station.

(10) In the case of separation from the service (discharge and does not reenlist or dies) or a cure, the registers have been sent to The Surgeon General.

(11) How many members of the command are recorded on syphilitic registers.

(12) How many are taking active treatment.

(13) How many are on a rest period.

(14) Syphilis is being managed in accordance with instructions of The Surgeon General (circular letter No. 18, S. G. O., 1941).

(15) How many syphilitic registers have been sent to The Surgeon General in the past 12 months (AR 40–235).

b. (1) Prophylactic station is conveniently located in a separate room, sufficiently lighted, well painted, clean, and properly equipped.

(2) It has running water available over a trough or individual sinks.

(3) A high degree of privacy is insured.

(4) Liquid soap is kept on hand in suitable, accessible containers.

(5) A fresh (1 to 1,000) bichloride solution is kept in containers properly labeled as to contents so located that it may be readily used as a wash at the sink or trough.

(6) It is kept under lock and key when not in use.

(7) How many syringes are kept on hand.

(8) Standard blunt type is used.

(9) How syringes are sterilized.

(10) Wooden spatulas (tongue depressors) are on hand for use in ointment jars.

(11) Solution of protargol is kept fresh in a dark, marked, and dated bottle.

(12) How the protargol solution is made up, from weighed stock kept in the station or made up in the pharmacy.

(13) How often the protargol solution is prepared.

(14) Any wastage of protargol.

(15) Calomel ointment is kept on hand at all times.

(16) Roll paper on hand is used for towels, etc.

(17) Regulations are posted for the *conduct* of the station.

(18) Regulations are posted for the technique of prophylaxis.

(19) Blank forms are on hand to record the treatment.

(20) Who is directly in charge of the station.

(21) Station is inspected each morning.

(22) Every man detailed to duty in the station is instructed in the procedure and technique of prophylaxis.

(23) He understands that the cleansing operation should be given the importance of a surgical procedure.

(24) Above also applies to emergency men who may be required to administer the treatment at night.

(25) File of retained prophylaxis records, W. D., M. D. Form No. 77, indicates that every form is complete, bears the notation as to the absence of venereal disease, has the signature of the attendant and of the patient, and bears the initials of a medical officer.

(26) It is a rule that patients will always be examined for evidence of venereal disease prior to the administration of prophylaxis (AR 40–235 and Army Medical Bulletin No. 23).

c. (1) How frequently lectures are given to all enlisted men by medical officers (AR 40–235).

(2) What steps have been taken to inform the command about venereal prophylaxis (AR 40–235).

(3) Instructions pertaining to individual prophylaxis (individual prophylactic packet) are being complied with (AR 40–235, and circular letter No. 4, S. G. O., 1940).

(4) What the new case rate is per 1,000 per annum for venereal disease for the command for the past month.

(5) What the prophylactic rate is per 1,000 for the past month.

(6) How many of the cases of venereal disease reported during the past month were contracted in the vicinity of the post.

(7) Men are tried by court martial if they fail to report venereal disease.

(8) Any marked difference in venereal rates for various units of the command.

(9) What means are used to restrict venereal cases to the post while in the infectious stage (AR 40–235).

d. Physical inspections are held monthly and without notice (AR 615–250).

e. (1) How many cases of gonorrhoea now in hospital.

(2) How many cases of syphilis now in hospital.

(3) How many cases of chancroid now in hospital.

(4) How many cases of gonorrhoea now taking out-patient treatment.

(5) How many cases of syphilis now taking out-patient treatment (AR 40–235).

f. (1) What the general character is of treatment for hospitalized cases of—

(*a*) Gonorrhoea.

(*b*) Syphilis.

(*c*) Chancroid.

(See circular letter, No. 18, S. G. O., 1941.)

(2) (*a*) Usual duration of stay in hospital for cases of gonorrhoea.

(*b*) Patients with gonorrhoea are retained in hospital until fully cured.

(3) General character of treatment for out-patient cases of gonorrhoea.

(4) If such patients are marked duty before a complete cure is effected what method is used to insure their restriction to limits or quarantine.

(5) What check is made to insure that all patients are given proper and regular treatment.

(6) How often such patients receive treatment.

(7) What record is kept of out-patient treatments for gonorrhoea.

(8) How often such patients are seen by a medical officer.

(9) Who gives irrigations and injections for patients with gonorrhoea.

(10) Types of syringes used for injections.

(11) Attendants on this service are properly instructed.

(12) Place used for out-patient treatment of cases of gonorrhoea is suitable.

g. (1) Tests used to determine a final cure in cases of gonorrhoea.

(2) When a venereal patient is cured how his organization commander is notified.

(3) Equipment, including instillator and apparatus for irrigation, is available.

(4) Irrigation, dilatation, instillation, and prostatic massage is employed in appropriate cases.

(5) Any evidence of indifference or negligence manifested in treating venereal cases, or it is considered that all venereal cases receive painstaking and appropriate treatment.

(6) Complications of gonorrhoea exist with undue frequency and what proportion of acute cases become chronic.

(7) Vaccines are used, and what are results.

(8) Silver salts, if used, are always freshly prepared.

(9) Venereal patients are carefully questioned with a view of identification of infected prostitutes (AR 40–235).

3. Operating section.—*a.* Organization of the operating service (AR 40–590).

b. Medical supplies are adequate and satisfactory (AR 40–1705, Medical Department Supply Catalog, and circular letter No. 1, S. G. O., 1940).

c. All medical property is secure from theft, fire, and other damage (AR 40–590).

d. Any accumulation of supplies or equipment on hand above present needs (AR 40–1705).

e. Any obsolete, damaged, or unserviceable property on hand (AR 40–1705 and AR 700–10).

f. There is a file of property held on memorandum receipt (W. D., M. D. Form No. 16b) (AR 40–1705).

g. Medical property has been examined and *verified* by a commissioned officer of the Medical Department during the last 6 months (AR 40–1705).

h. Alcohols, narcotics, and potent poisons are kept under lock and key (AR 40–590).

i. Catheters and other rubber goods are protected by the use of talc.

j. Greatest care is used with electrical heating units to avoid burning out the heating coils (AR 40–1705).

k. Responsible medical officer checks the surgical instruments monthly as required (AR 40–1705).

l. Regulations and instructions for the guidance of the operators and attendants are posted (AR 40–590).

m. Any inflammable material exposed to the danger of fire in any of the rooms of this service (AR 700–10).

n. (1) How many major operations performed during the last month.

(2) How many minor operations performed during the last month.

(3) How many obstretrical cases handled during the last 6 months.

(4) Any cases of puerperal sepsis.

(5) Any cases of post-operative pneumonia during the last 6 months.

(6) Any cases of G. C. ophtalmia.

(7) Any cases of post-operative infections during the last 6 months.

o. (1) Operating personnel are satisfactory and sufficient.

(2) Anesthetist has been specially trained for the work.

(3) Operating and dressing room attendants are well qualified.

(4) Attendants have a clear understanding of the technique of aseptic operating.

p. (1) Routine instructions are published for preparation of patients before major operations.

(2) Routine instructions are published for the after care of patients following a major operation (AR 40–590).

q. (1) Types of sterilizing equipment in use.

(2) Fractures are treated in accordance with instructions (circular letter No. 22, S. G. O., 1940).

(3) Glucose solutions for intravenous use are being properly prepared (circular letter No. 2, S. G. O., 1940).

(4) What equipment is made ready to care for any emergency arising during a major operation.

4. Surgical wards.—*a.* Organization of the surgical service (AR 40–590).

b. See paragraph 3*b* to *h*, above.

c. A file is maintained of the nonexpendable medical supplies in use in the ward on W. D., M. D. Form No. 16b (AR 40–1705).

d. Ward officer checks the surgical instruments monthly as required (AR 40–1705).

e. Any inflammable material exposed to the danger of fire in any of the wards or closets (AR 700–10 and AR 40–590).

f. (1) The head nurse, under the ward officer, is placed in charge of the ward, of the nurses, of the enlisted personnel and others who assist in the care of patients (AR 40–20 and AR 40–590).

(2) She records all instructions from the ward officer for the guidance of both day and night nurses (AR 40–20 and AR 40–590).

(3) She is held responsible for the proper nursing of patients, serving of all food, the administration of medicines, and the cleanliness and order of the ward and of the public property therein (AR 40–20 and AR 40–590).

g. (1) In the absence of members of the Army Nurse Corps, the enlisted attendant (wardmaster) is in charge of the ward, and he has responsibility in the same degree and manner as a head nurse (AR 40–590).

(2) Enlisted attendants are required to comply with the instructions of nurses in the execution of their offices (AR 40–590).

(3) Smoking by ward personnel while on duty in wards is prohibited (AR 40–590).

(4) Enlisted attendants wear the white uniform at all times when on duty in wards (AR 40–590).

(5) Enlisted men on duty are forbidden to collect or hold money or other valuables belonging to patients or to have financial transactions with them (AR 40–590).

h. (1) Upon admission to the ward the patient is advised to deposit his money and valuables for safekeeping in the safe provided for that purpose, and that he keeps valuables in the ward at his own risk (AR 40–590).

(2) In case a patient is unconscious or seriously ill, the ward officer secures his valuables at once, in the presence of a witness, and secures a receipt therefor from the custodian (AR 40–590).

(3) Soiled clothing of patients is laundered at Government expense as a part of the hospital laundry (AR 40–590).

(4) Patient's clean clothing is listed in duplicate on W. D., M. D. Form No. 75 in his presence (or in the presence of a witness in case the patient is unconscious or insane), signed by the patient (if conscious), bundled and tagged and properly and securely stored (AR 40–590).

i. (1) Patients are properly dressed in hospital clothing.

(2) Patient's temperature, pulse, and respiration are taken and recorded at once on W. D., M. D. Form No. 55 G–1, showing the time the patient was admitted to the ward.

(3) Patient is bathed, clothed in hospital clothing, and put to bed upon arrival unless otherwise instructed by a responsible medical officer.

(4) If a patient shows any indication for prompt medical or surgical attention the nurse informs the ward officer or responsible medical officer.

(5) What the standing instructions are relative to nourishment pending the prescribing of a diet by a medical officer.

(6) How long patients are in the ward before a complete detailed history and a physical examination are made.

j. (1) Until what hour of the day patients are required to remain in their wards.

(2) Use of profane language, loud talking, singing, or boisterous actions are forbidden in the ward.

(3) Patients are permitted to smoke in the wards. If so, what portion of the ward and at what hour.

(4) Gambling is forbidden.

(5) How often ambulatory patients are required to bathe and change their hospital clothing.

(6) Patients are prohibited to use towels, basins, toilet articles, or articles of clothing belonging to other patients.

(7) Patients are required to report to the ward officer any inattention regarding care and treatment, or any dissatisfaction regarding the character, quantity, or manner of serving of food.

(8) In what manner infractions of discipline by patients are handled (AR 40–590).

(9) (*a*) When death is imminent the patient is properly segregated from other patients.

(*b*) In case of death, the body is examined by a responsible medical officer before being removed from the ward.

(*c*) Remains are promptly removed to the morgue.

(*d*) Body is properly tagged, washed, orifices properly cared for, clothed in clean linen, and the remains wrapped in a clean sheet (AR 40–590).

k. A ward morning report is prepared covering all cases admitted, disposed of, or transferred to or from the ward in the previous 24 hours, ending at midnight (AR 40–590).

l. What hour daily diet request and mess storeroom request are signed and sent to the mess officer (AR 40–590).

m. Complete clinical histories (W. D., M. D. Form No. 55-series) are available for use (AR 40–1025).

n. Clinical records are forwarded to the registrar for a check 24 hours before the patient is discharged from hospital.

o. All orders for medicine or treatment are recorded in the ward order book by the nurse receiving the orders and the book is signed by the ward officer before he leaves the ward.

p. In checking narcotics and alcohols the ward officer's order book is checked against the record of administration of medicine to patients.

q. At what hours of the day routine pulse rates, temperatures, and respiration are taken.

r. Clinical records of patients are kept in places where patients or visitors may have access to same.

s. (1) Dietitian head nurse is responsible for the service of meals.

(2) She is required to make full report when food is not satisfactory.

(3) She attempts to rectify immediately any mistakes observed.

(4) Proper tray service is provided for all bed patients.

(5) Tray service is attractive, food appetizing, and promptly served upon reaching the ward.

(6) There is a sufficient variety and quantity in each meal.

(7) Food is properly cooked.

(8) Any waste.

(9) Attendants are permitted to eat in the wards or diet kitchens.

(10) Ward officer personally inspects the service of one meal daily in his ward.

(11) Ward officer specifically states the patients who will go to the dining room for meals.

(12) System used to transport food to the ward.

(13) Measures taken to insure that foods will be served hot to the bed patients.

(14) Bills of fare for diets prescribed by the commanding officer are made out and posted in the ward office (AR 40–590).

t. (1) Ward officer makes a complete and detailed inspection daily, including sanitation, neatness, upkeep, and repair of equipment, outside police of ward areas, and the general administration of his ward.

(2) What action he takes to correct defects and deficiencies noted at the inspection (AR 40–590).

APPENDIX IX

CHECK LIST FOR CHIEF OF MEDICAL SERVICE

1. General.—*a.* Organization of the medical service (AR 40–590).

b. (1) How often a complete inspection is made by chief of medical service of the entire service.

(2) How frequently professional conferences are held.

c. Copies of hospital rules are posted in convenient places where they may be seen by patients and duty personnel (AR 40–590).

d. (1) Patients with communicable diseases are isolated individually or in groups (AR 40–245).

(2) A special section of the hospital is set aside for their management (AR 40–245).

(3) Cubicle frames are provided (AR 40–245).

(4) Patients with communicable diseases are restricted to the portion of the hospital set aside for their treatment during the communicable stage (AR 40–245).

(5) Visiting is prohibited between patients with the various classes of communicable diseases (AR 40–245).

(6) Beds, mattresses, and linen of such patients are properly disinfected when the patient is released from the ward (AR 40–245).

(7) Cases with respiratory tract infection are required to use paper napkins or pieces of gauze as handkerchiefs and these articles are burned after use (AR 40–245).

(8) Their dishes, knives, forks, etc., are sterilized after use (AR 40–245).

(9) Patients with venereal diseases in a communicable stage are isolated from all other patients (AR 40–245).

e. Ward attendants are fully instructed in methods of protection from diseases for themselves and for others (AR 40–245).

f. A suitable, properly secured room is set aside for the care of mental cases (AR 600–500).

g. Keys to mental wards and prison ward are so handled that these wards can be entered quickly at any time in case of fire, disorder, or for search (AR 40–590).

h. A Morning Report of Ward (W. D., M. D. Form No. 72) is accompanied by diagnosis slips for the new admissions furnished the registrar each morning (AR 40–590).

i. How transfers of patients from one ward to another ward are handled (AR 40–590).

j. Prompt action is taken to dispose of patients actually determined insane (AR 600–500).

k. Prison ward is suitable and properly secured by locks and keys (AR 600–375).

2. Medical ward.—*a.* Organization of the medical ward section (AR 40–590).

b. *See* paragraph 4, appendix VIII.

APPENDIX X

CHECK LIST FOR OFFICER IN CHARGE OF LABORATORY

1. Room or building used as a laboratory is suitable. If not, state requirements (AR 40–585 and AR 40–590).

2. Personnel assigned to duty in the laboratory are sufficient, well trained, and satisfactory (AR 40–590).

3. Laboratory equipment and supplies are sufficient and satisfactory. If not, state requirements (AR 40–1705, Medical Department Supply Catalog, and circular letter No. 1, S. G. O., 1940).

4. Greatest care is used in handling electrical heating units in order to avoid burning out of heating coils (AR 40–1705).

5. Potent poisons and alcohols are kept under lock and key (AR 40–590).

6. Ethyl alcohol is accounted for on W. D., M. D. Form No. 17a as in a pharmacy (AR 40–590).

7. Any accumulation of supplies or equipment on hand in excess of present requirements (AR 40–1705).

8. Any obsolete, damaged, or unserviceable supplies or equipment on hand (AR 40–1705 and AR 700–10).

9. Officer in charge maintains a record on W. D., M. D. Form No. 16b of nonexpendable supplies (AR 40–1705).

10. Officer in charge checks his instruments monthly (AR 40–1705).

11. Medical property in the laboratory has been examined by a commissioned officer of the Medical Department and *verified* by reference to records within the last 6 months (AR 35–6520 and AR 40–1705).

12. All medical property is protected from the danger of fire, theft, and damage (AR 40–590).

13. Rubber goods are protected by the use of talc.

14. Any inflammable material stored in the laboratory that is not properly protected from the danger of fire (AR 700–10).

15. *a.* Laboratory animals are suitably housed and protected.

b. Laboratory animals are in good condition.

c. What funds are available for their upkeep.

16. How often the water in the swimming pool is examined.

17. *a.* What examinations are made at the laboratory.

b. What types of examinations are not made at the laboratory but are sent to other Government agencies.

18. *a.* A list of voluntary blood donors, by types, is kept on file at the laboratory.

b. How often these donors are examined for syphilis (AR 40–1715).

19. Arrangements are made so that the laboratory officer or one of his qualified assistants is available at all times for blood counts, etc.

20. *a.* All suspected venereal sores examined by dark field method for spirochetae pallida.

b. If the first examination is negative, other examinations are made later (circular letter No. 1, S. G. O., 1940).

21. *a.* All autopsies are performed by an officer assigned to the laboratory service.

b. Chief of laboratory service is held responsible for all bodies from the time they are delivered from the ward until they are turned over to the undertaker.

c. A receipt is obtained from the undertaker for all bodies turned over to him.

d. Bodies are inspected immediately after death and again after they are properly clothed and ready to be placed in the casket (AR 30–1820).

e. A certificate of the inspection, signed by an officer of the laboratory service, stating whether or not the body is properly prepared and properly clothed for burial, is filed in the hospital records.

f. A copy of the records of each autopsy is forwarded direct to the Curator, Army Medical Museum (AR 40–590).

g. Tissue pathology is handled in accordance with The Surgeon General's instructions (par. 24, circular letter No. 1, S. G. O., 1940).

APPENDIX XI

CHECK LIST FOR CHIEF OF DENTAL SERVICE

1. Rooms set aside for the dental clinic are suitable, well lighted, clean and neat in appearance (AR 40–15 and AR 40–590).

2. Opinion of the dental surgeon is secured in writing when the construction, improvement, or upkeep of the dental clinic is under consideration. In such cases the dental surgeon forwards a copy of his recommendations through channels to The Surgeon General (AR 40–15 and AR 40–585).

3. A suitable waiting room has been set aside for dental patients (AR 40–15).

4. Dental personnel are sufficient. If not, detail the need for additional personnel (AR 40–15).

5. Enlisted men assigned to dental service are regarded as being on special duty and under special instruction, and not required to attend any other form of instruction (AR 40–15).

6. Dental surgeon has prepared schedules for the technical training of his enlisted assistants, including hours of duty with the dental service, dental first-aid measures, care of public property, etc. (AR 40–15).

7. Regulations have been drawn up for the dental service, including hours of duty, property regulations, sanitation, the keeping of records etc. (AR 40–590).

8. *a.* Dental surgeon regularly makes such inspections and checks of dental supplies and equipment as will insure that the property is in serviceable condition at all times (AR 40–1705).

b. He inspects his instruments once a month (AR 40–1705).

c. He maintains a file showing the nonexpendable property for which he is responsible (AR 40–1705).

d. Dental supplies are satisfactory as to kind, quantity, and quality (AR 40–15, AR 40–1705, and Medical Department Supply Catalog).

e. Dental surgeon pays special attention to the safekeeping and proper use of poisons, narcotics, alcohol, and substances containing alcohol (AR 40–15 and AR 40–590).

f. Poisons, narcotics, and alcohols are kept under lock and key (AR 40–15 and AR 40–590).

g. Who is intrusted with the key to the poison cabinet (AR 40–15 and AR 40–590).

h. Gold plate, gold for casting, gold solder, and gold lingual bars are kept in a safe, except when small quantities for daily use are kept in a safe place in the dental clinic (AR 40–15).

i. If a dental officer is relieved from duty he turns over his stock of special dental material either to the medical supply officer or to his successor, obtaining and distributing copies of the receipts (AR 40–15).

j. When unserviceable gold accumulates, it is mailed in a registered package to the distributing depot for the corps area, in weights not to exceed 5 pennyweight (AR 40–1705).

k. Any unserviceable gold on hand (AR 40–1705).

l. Dental clinic is properly protected from theft, fire, and other damage (AR 40–590).

m. Any accumulation of property or supplies on hand (AR 40–1705).

n. Any obsolete, damaged, or unserviceable property on hand in the dental clinic (AR 40–1705 and AR 700–10).

o. Medical property in the dental clinic has been examined and verified by a commissioned officer of the Medical Department within the last 6 months (AR 35–6520 and AR 40–1705).

p. It is understood by all concerned that the greatest care must be used with heating units to avoid burning out of the heating coils (AR 40–1705).

9. All inflammable material is protected from the danger of fire (AR 700–10).

10. *a.* Dental surgeon makes an oral inspection at the time the surgeon conducts the monthly physical inspection (AR 40–15 and AR 615–250).

b. A dental survey is made of every patient who is hospitalized (AR 40–15).

c. Date of the last complete dental survey of the command (AR 40–510).

d. Present dental classification of the command.

Class I Class II Class III Class IV

(AR 40–510).

e. Appointments are made in accordance with the result of the classification (AR 40–510).

11. What administrative action is taken to insure that the following persons report to the dental surgeon for examination and necessary dental treatment:

a. Persons ordered to permanent detached service.

b. Persons who may be performing detached service while attending summer training camps and such other times as they may be at the station (AR 40–510).

12. In examining or treating persons who may be performing detached service while attending summer training camps the dental surgeon forwards a statement of conditions found and defects corrected, if any, and in case the treatment is not completed the reasons therefor, to the corps area surgeon of the corps area in which the individual is stationed (AR 40–510).

13. *a.* Dental surgeon keeps an appointment book.

b. Method used in making appointments with military personnel.

c. What percent of personnel fails to keep appointment.

d. Dental treatment is accorded to all who are entitled to receive it.

e. There is a daily emergency hour, and how it relates to sick call.

f. How many hours during the coming week are taken up with appointments.

g. Regulations are in force requiring that the name, grade, etc., of every militarized person in need of dental attention be placed on the daily sick report (W. D., A. G. O. Form No. 5), and the individual required to report at the hospital or dispensary (enlisted men on sick call) before dental treatment is rendered by the dental service (AR 40–505, AR 40–510, AR 40–1025, and AR 345–415).

14. Dental surgeon has trained his enlisted assistants to keep the records of the clinic (AR 40–15).

15. *a.* How many full dentures made during each month of the past year.

b. How many partial dentures.

c. Any unreasonable delay in furnishing dentures.

16. A record is kept of dental X-ray exposures (AR 40–15).

17. There is a current file and a permanent file of register cards of dental patients (W. D., M. D. Form No. 79) (AR 40–1010).

18. In cases where patients were hospitalized for dental treatment only, the chief of dental service furnishes the ward officer with a copy of the patient's case record to be attached to the patient's clinical record.

19. Patients in the hospital who require dental examination and report or dental treatment are sent to the dental clinic with a report from the ward officer showing name, etc., and whether referred for dental examination or treatment, or both, the patient's diagnosis, his probable duration of hospitalization, together with any remarks pertinent to the case, with special reference to the presence of syphilis in the infectious stage.

20. At the close of each month the following reports are fastened together and filed as "Dental history, Fort ———, for the month of ———."

a. W. D., M. D. Form No. 57.
b. W. D., M. D. Form No. 18b.
c. Report of dental opinions on clinic.
d. Schedules of instruction for enlisted assistants.
e. Memoranda recommended for incorporation in sanitary order.
f. Special reports and articles for publication.
g. Other pertinent data.
(AR 40–1010).

21. At the close of each calendar year an index has been made of all subjects listed above and filed as "Index to the dental history, Fort ———, year of ———" (AR 40–1010).

22. Dental surgeon keeps himself informed of existing or anticipated conditions with reference to their influence on dento-oral health, and he communicates such of this information as has a bearing upon military administration to the surgeon and recommends to him measures deemed advisable (AR 40–15).

23. Dental reports are checked as to accuracy (par. 12, circular letter No. 1, S. G. O., 1940).

24. Instructions regarding central dental laboratories are being complied with (par. 11, circular letter No. 1, S. G. O., 1940, and references quoted therein).

APPENDIX XII

CHECK LIST FOR CHIEF OF ROENTGENOLOGICAL SERVICE

1. *a.* Personnel assigned to duty in the department are adequate.

b. Personnel are competent.

c. Conduct and appearance of the personnel are satisfactory (AR 40–590).

2. *a.* Hospital property used for other than Medical Department purposes (AR 40–590).

b. Property is protected from theft, fire, and other damage (AR 40–590).

c. Any accumulation of property or supplies on hand above present needs (AR 40–1705).

d. Any obsolete, damaged, or unserviceable property on hand (AR 40–1705 and AR 700–10).

e. A file is kept showing property held on Memorandum Receipt (W. D., Q. M. C. Form No. 487) (AR 40–1705).

f. Supplies are adequate and satisfactory (AR 40–1705, Medical Department Supply Catalog, and circular letter No. 1, S. G. O., 1940).

g. Medical property in use has been examined and *verified* by a commissioned officer of the Medical Department every 6 months (AR 35–6520 and AR 40–1705).

h. Potent poisons are kept under lock and key and labeled as such (AR 40–590).

i. Instruments of every description are checked monthly by a commissioned officer (AR 40–1705).

j. Daily average number of X-ray pictures taken during past month. Small size. Medium size. Large size. Fluoroscopic examinations. X-ray treatments.

3. In view of fire hazards, accumulations of used X-ray films in evidence.

4. Plans have been submitted to The Surgeon General for the proper storage of X-ray films.

5. Standing instructions have been posted for the guidance of the technician, especially in regard to fire hazards, the storage of films, etc. (AR 40–590).

6. *a.* All electric wiring complies with the N. E. A. Code, especially in regard to the use of insulators, conduits, stand-offs, fuse blocks, switches, etc.

b. *Only* screened incandescent lamps are used.

c. Any portable lights on extension cords in evidence.

d. Diffusing glass in the illuminator ever becomes heated.

e. "NO SMOKING" signs are posted.

f. Any film kept within 2 feet of steam pipes, radiators, or other sources of heat.

g. Fire extinguishing appliances are readily available.

h. Any of the fire extinguishers in the department contain carbon tetrachloride, which will develop phosgene gas.

i. Films are in casettes or other containers in the operating room at any time other than while operating.

j. Film negatives in storage or in the process of handling are kept in heavy manila envelopes, or in cardboard boxes, not to exceed six films to the envelope or 25 to a box.

k. Films in the laboratory in excess of 100 pounds to one vented cabinet, or 200 pounds in two vented cabinets, are kept separated by at least 15 feet.

l. Films are stored in rooms which are shared with other activities.

m. Any accumulation of combustible material in the X-ray laboratory.

n. How deteriorated X-ray films are disposed of.

7. Equipment and space allotted for X-ray department are satisfactory.

APPENDIX XIII

CHECK LIST FOR OFFICER IN CHARGE OF DISPENSARY

1. Out-patient service furnishes medical attendance to all persons entitled thereto (AR 40–505).

2. *a.* At what hour sick call is held each day (AR 40–505).

b. It is a rule that every militarized person in need of medical attention will be placed on daily sick report (W. D., A. G. O. Form No. 5) (AR 345–415).

c. As a rule the organization or detachment daily sick report entries are completely filled out, including the line of duty (yes, no), and signed by the organization or detachment commander *before* being sent to the hospital or dispensary.

d. First entry for each occasion is made on the line immediately following the signature of the organization or detachment commander and medical officer to the preceding entry (AR 345–415).

e. Organization or detachment commander invariably places an interrogation point (?) in the proper column when he cannot state definitely at the time whether or not the disease or injury was incurred in line of duty (AR 345–415).

f. Surgeon in every case of injury considers whether or not the case may result in partial or complete permanent physical disability and be made the basis of a claim against the Government (AR 345–415).

g. If he believes that it may so result, he immediately takes steps to request the action of a board of officers (AR 345–415).

h. A noncommissioned officer of the organization or detachment brings the daily sick report to the place of holding sick call and waits to return the daily sick report (AR 345–415).

i. Entries in the daily sick reports show name, grade, and Army serial number (AR 345–415).

j. When the organization or detachment commander or the medical officer determines that the injury to an enlisted man resulted from his own misconduct, the notation "No; 107 AW" is made in the line of duty column (AR 345–415).

k. Similarly, if an absence from duty of an enlisted man is caused by venereal disease due to his own misconduct, the initial symptoms

of which appeared more than a year prior to such absence, the notation "No; 107 AW" appears (AR 345–415).

l. In case of an entry where the organization or detachment commander or the medical officer is of the opinion that the sickness of an officer or enlisted man was due to causes, as noted, "the effects of a disease which is directly attributable to and immediately follows his own intemperate use of alcoholic liquor or habit-forming drugs," this entry appears in the line of duty column, "No; AR 35–1440" (AR 345–415).

m. When an entry of "No; AR 35–1440" or "No; 107 AW" is made on the organization or detachment daily sick report, the individual is given an opportunity to protest the findings to the commanding officer (AR 345–415).

n. In case that the organization or detachment commander and the surgeon do not agree upon the line of duty status, the daily sick report is presented to the commanding officer for his decision to be placed in the "disposition" column and signed with his official signature (AR 345–415).

o. In all cases of the entry "No; AR 35–1440" the initials of the organization or detachment commander appear opposite both the original entry and final entry of the current case (AR 345–415).

p. Erasures appear on the daily sick report in violation of orders (AR 345–415).

q. When an incorrect entry has been made, a line is drawn through the entry and the initials of the officer making the elimination placed on the margin of the page (AR 345–415).

r. The signature, grade, and organization or arm or service of the organization or detachment commander and medical officer are placed on the line immediately below the last entry for each occasion, each officer signing *below the items of his report* (AR 345–415).

3. The medical officer in charge of the out-patient service conducts the prescribed physical examination of enlisted men (AR 615–250).

4. An out-patient index is kept in the out-patient service for all patients treated but not admitted to the hospital.

5. How out-patient records are disposed of when no longer required for current use (AR 40–1005).

6. A record is kept of the number of patients treated, number of treatments, examinations, etc., for use with the report sheet (W. D., M. D. Form No. 51) at the end of the month, and under these headings:

a. Out-patients:

(1) Military.

(2) Training unit.

(3) Civilian.

(4) Others (specify).
b. Physical examinations:
(1) Appointment, promotion, and annual of officers, etc.
(2) Enlistment and reenlistment in Regular Army.
(3) Appointment to United States Military Academy.
(4) Appointment, promotion, or others, Officers' Reserve Corps.
(5) Reserve Officers' Training Corps.
(6) Citizens' Military Training Camps.
(7) Enlisted Reserve Corps.
(8) Others (specify).
c. Vaccination, etc.:
(1) Typhoid immunizations.
(2) Smallpox vaccinations.
(3) Schick tests.
(4) Diphtheria toxin antitoxin.
(5) Others (specify).
(AR 40–1025).

7. How many patients were seen in the out-patient service during the last completed month (AR 40–1025).

8. A summary of the work to include number of office visits, quarters visits, number of persons carried in quarters (by classes) is furnished the surgeon on the last day of each month (AR 40-1025).

9. The chief of each professional service is required to submit on the first day of each month a report to the medical officer in charge of the out-patient service showing the total number of treatments given out-patients during the preceding month in the various services and clinics under their jurisdiction.

10. *a.* Medical property for which the medical officer in charge is responsible has been examined and *verified* by a commissioned officer of the Medical Department during the last 6 months (AR 35–6520 and AR 40–1705).

b. Medical officer in charge checks the instruments for which he is responsible monthly (AR 40–1705).

c. A record is kept on Form No. 16b of the supplies for which the medical officer in charge is responsible (AR 40–1705).

d. Medical officer in charge safeguards the potent poisons, alcohol, alcoholic liquors, narcotics, and habit-forming drugs which he may carry in emergency cases by the use of lock and key (AR 40–590).

11. It is clearly understood by medical officers on duty that sulfanilamide will be employed only when the patient is kept under careful medical supervision in hospital and that it will not be administered to out-patients (par. 4, S. G. O. circular letters No. 13, 1938, and No. 17, 1940).

APPENDIX XIV

CHECK LIST FOR OFFICER IN CHARGE OF PHARMACY

1. Commanding officer of the hospital exercises personal supervision over the pharmacy or he has detailed a subordinate Medical Department officer for this duty (AR 40–590).

2. The pharmacy is generally clean, well lighted, and it presents a neat appearance (AR 40–590)

3. Pharmacist on duty appears to be well qualified for his duties (AR 40–590).

4. What members of the detachment are permitted to compound prescriptions and under what circumstances (AR 40–590).

5. All prescriptions are written in the metric system (AR 40–590).

6. A separate prescription file is kept for prescriptions containing alcohol, alcoholic liquors, and for medicines containing opium or any of the salts, derivatives, or preparations of opium or coca leaves (AR 40–590).

7. A separate prescription file is kept for prescriptions for civilians (AR 40–590).

8. All other prescriptions are filed in a separate book (AR 40–590).

9. Labels placed on containers for medicines issued from the pharmacy bear complete instructions to the patient and notations to identify the prescriber and prescription (TM 8–233).

10. Initials of the pharmacist who filled the prescription are entered on each prescription (TM 8–233).

11. *a.* Officer in charge of the pharmacy assumes responsibility for safeguarding the use of the key.

b. Exactly to whom the keys of the poison cabinet are intrusted.

c. Who has the keys when the pharmacist is off duty (AR 40–590).

12. Unduly large amounts of alcoholic liquors have been prescribed at one time for any one person (AR 40–590).

13. A permanent record is kept of the pharmacy receipts and expenditures for each article such as alcohol, alcoholic liquors, and all habit-forming drugs on W. D., M. D. Form No. 17a (AR 40–590).

14. The slips (W. D., M. D. Form No. 17a) have been checked once a month by a Medical Department officer, balanced and verified, and the facts with the balance he found noted over his signature (AR 40–590).

15. On each slip mentioned above, the date of receipt from the storeroom is noted in the left-hand column, and the amount in the

proper *metric* unit entered in the debit column; the expenditures noted by date, prescription number in the left hand column with the amount expended in compounding the prescription in the credit column (AR 40–590).

16. A separate slip is kept for each form in which the above-named drugs are furnished. For instance, morphine is issued in four forms:

12940 Morphine sulfate, 1 oz. USP, powder.
12950 Morphine sulfate, 1/8-grain hypo tablets, 20, USP.
12955 Morphine sulfate, 1/4-grain hypo tablets, 20, USP.
12960 Morphine sulfate, 2-grain hypo tablets, 10, USP.

(AR 40–590 and AR 40–1705).

17. The entries on W. D., M. D. Form No. 17a are correct for each of the drugs noted below, since date of the last medical inspection. (Secure a list of the issues from the storeroom and check expenditures from the prescription files.) (AR 40–590).

10480 Alcohol, ethyl, 1 qt. USP.
10490 Alcohol, ethyl, 5 gal. USP.
10500 Alcohol, dehydrated, 1 pt. USP.
11450 Cocaine, hydrochloride, 1/4 oz. USP.
11480 Codeine, sulfate, 1 oz. USP.
11490 Codeine, sulfate, 1/2-grain tablet, 500, USP.
12940 Morphine, sulfate, 1 oz. USP.
12950 Morphine, sulfate, 1/8-grain hypo tablets, 20, USP.
12955 Morphine, sulfate, 1/4-grain hypo tablets, 20, USP.
12960 Morphine, sulfate, 2-grain hypo tablets, 10, USP.
13220 Opium, 1 oz. powder, USP.
14850 Tincture, opium 1/4 pt. USP.
14860 Tincture, opium, camphorated, 1 pt. USP.
14940 Whisky, 1 qt. USP.
Nonstandard items corresponding to the above.

18. The poison label is placed on every container when the contents thereof may be dangerous to health or human life (TM 8–233).

19. Potent poisons, that is, "any substance (drug, chemical, or reagent) which is likely to destroy human life or seriously endanger health when applied externally to the body or when taken internally in a dose of less than one teaspoonful (4 cc., or in the solid state, 4 gm.)", alcohol, alcoholic liquors, and all habit-forming drugs are kept under lock and key (AR 40–590).

20. The following-named drugs, etc., are kept under lock and key, or are any of them exposed on the shelves or kept in drawers:

Acid, nitric.
Acid, oxalic.
Acid, phosphoric.
Acid, sulphuric.

Alcohol, methyl.
Amyl nitrite.
Antimony and potassium tartrate.
Apomorphine.
Arsenic.
Atropine.
Barbital or veronal.
Cantharides.
Chloral hydrate.
Cresol.
Digitalis.
Fl. ext. belladonna.
Fl. ext. nux vomica.
Glyceryl trinitrate
Homatropine.
Iodine.
Mercury.
Nux vomica.
Phenol.
Physostigmine.
Potass. hydroxide.
Procaine.
Scopolomine.
Silver nitrate.
Sod. hydroxide.
Strophanthin.
Strychnine.
Tinct. aconite.
Tinct. belladonna.
Tinct. digitalis.
Tinct. nux vomica.
Alcohol, ethyl.
Cocaine.
Codeine.
Morphine.
Opium.
Whisky.
Other liquors.

21. A prescription is made out every time that medicine is issued, as is customary in good practice.

22. Prescriptions are refilled without a written order calling for a refill by number (TM 8–233).

23. A refill date and number are placed on the old prescription (TM 8–233).

24. In cases other than militarized personnel, a notation is placed on each prescription immediately after the name of the individual so as to enable the pharmacist to determine the status; for example, "John Smith, civilian employee, Q. M. C."

25. When prescribing for civilian employees of the United States and civilians as out-patients (dependents of military personnel excepted), medical officers are required to enter on each such prescription the amount to be collected.

26. Medicine charges for patients in hospital who are not entitled to medical relief at the expense of the War Department appropriations, such as certain civilian employees and other civilians, are collected promptly at the rate of 50 cents per diem, listed on War Department Form No. 322, deposited at the end of each month with nearest disbursing officer, and The Surgeon General notified of the fact by letter (AR 40–590).

27. Is this station an isolated place within the meaning of paragraph 18*c* (3), AR 40–590.

28. If this station is considered an isolated place is it customary to issue medicines to civilians, make charges and collect the same, notifying The Surgeon General of the circumstances in each case (AR 40–590).

29. Medicine charges for civilian employees not in hospital are collected at the rate of 50 cents per prescription in ordinary cases and in the case of expensive medicines, dressings, appliances, etc., at such increased rate as will reimburse the United States for their cost (AR 40–590).

30. When civilian employees are hospitalized because of injury incurred in the performance of duty and their medical care has not been assumed by the Army as a part of their compensation, bills for medicine charges are mailed direct to the United States Employee's Compensation Commission and the receipt of the funds from the Commission taken up on War Department Form No. 322, and deposited (AR 40–590).

31. *a.* A chart or table is kept in a conspicuous place in the pharmacy showing antidotes for such ordinary poisons as follows (TM 8–233):

Acids:
- Carbolic.
- Hydrocyanic.
- Oxalic.

Aconite.
Alcohols.
Alkalies.
Alkaloids.
Antimony.
Arsenic.
Corrosive sublimate.
Iodine
Lead salts.
Opium and morphine.
Phosphorus.
Snake venoms, etc.

b. Antidotes to specific poisons are properly labeled, kept in a convenient place for emergency use (TM 8–233).

32. All medicine containers are clearly and properly labeled (TM 8–233).

33. A list of prescriptions (stock formulas) for pharmaceutical preparations carried in stock is available at the pharmacy for the information of medical officers.

34. The pharmacy is required to keep continually on hand as far as practicable a complete supply of all medicines supplied for use of the hospital.

35. Any accumulation of supplies or equipment on hand in excess of present requirements (AR 40–1705).

36. Any obsolete, damaged, or unserviceable supplies or equipment on hand (AR 40–1705 and AR 700–10).

37. The officer in charge maintains a record of nonexpendable supplies on W. D., M. D. Form No. 16b (AR 40–1705).

38. Medical property in the pharmacy has been examined by a commissioned officer of the Medical Department and *verified* by reference to records within the last 6 months (AR 35–6520 and AR 40–1705).

39. Any inflammable material stored in the pharmacy that is not properly protected from the danger of fire (AR 700–10).

40. Proper precaution is taken in regard to smoking while handling inflammable supplies (AR 40–590).

41. Proper precautions are observed to safeguard adequately sulfanilamide to prevent unauthorized use (par. 6, circular letter No. 13, S. G. O., 1938, and circular letter No. 17, S. G. O., 1940).

INDEX

INDEX

INDEX

INDEX

INDEX

INDEX

INDEX

INDEX

INDEX

TECHNICAL MANUAL

FIXED HOSPITALS OF THE MEDICAL DEPARTMENT (GENERAL AND STATION HOSPITALS)

CHANGES NO. 1

WAR DEPARTMENT,
WASHINGTON, March 31, 1942.

TM 8–260, July 16, 1941, is changed as follows:

6. Supply.—*a.* The *initial* supplies * * * may be directed. In order to visualize the amount of supplies and equipment necessary to equip a general hospital, reference is made to the following approximate figures: Net weight, **408,488** pounds; shipping weight, **754** tons; volume, **30,000** cubic feet; freight cars required, **13.6**; trucks 1½-ton, 73.3. The number of separate packages required to pack the initial supplies for a general hospital is 2,474, but if the individual items are counted the total runs up to 100,000.

* * * * * * *

[A. G. 062.11 (12–30–41).] (C 1, Mar. 31, 1942.)

20. Function.—The functions are—

* * * * * * *

d. Information given out.—**Information concerning the condition of sick and wounded, necessary to allay the anxiety of friends, is given freely under the instructions of the commanding officer, except that in no instance is the diagnosis or information which might be used as a basis for a claim against the Government furnished. Such requests are referred to the adjutant or the executive officer.**

* * * * * * *

[A. G. 062.11 (12–30–41).] (C 1, Mar. 31, 1942.)

42. Admission of patients.—*a. General.*—(1) All patients are admitted through the receiving and disposition office, where the required admission data are made of record **and** assignment to a proper ward effected. In emergency the patient may be taken direct to the ward and the necessary admission data obtained later.

* * * * * * *

[A. G. 062.11 (12–30–41).] (C 1, Mar. 31, 1942.)

55. Property.

* * * * * * *

b. Exchange and replacement.

* * * * * * *

(2) All supplies classed as **"supervised"** by The Surgeon General which have become unserviceable through fair wear and tear in the public service are accompanied with a certificate in quadruplicate

signed by the responsible officer covering the unserviceability. This certificate gives all information required by paragraph 3*b*, Medical Department Supply Catalog.

* * * * * * *

[A. G. 062.11 (12-30-41).] (C 1, Mar. 31, 1942.)

59. Transfer of property.

* * * * * * *

b. Upon receipt of orders for change of station or upon change of duties which require transfer of accountability, the medical supply officer **will transfer the property to his successor in accordance with the provisions of AR 35-6680.** In the event that his authorized relief has not reported prior to the departure of the medical supply officer, an officer of the Medical Department is temporarily appointed to assume medical accountability, receipt being taken as required in AR 35-6680.

* * * * * * *

[A. G. 062.11 (12-30-41).] (C 1, Mar. 31, 1942.)

70. Procedure for other than separation from service or transfer to another hospital.

* * * * * * *

b. Patients on enlisted status.

* * * * * * *

(2) Prior to the discharge of enlisted patients other than from command, the commanding officer, detachment of patients, furnishes the patient with a clearance form and instructs him to have it initialed by the heads of the departments concerned and return the form to the detachment of patients office, where it is filed in his 201 file.

* * * * * * *

[A. G. 062.11 (12-30-41).] (C 1, Mar. 31, 1942.)

71. Separation from service or transfer to another hospital.—*a. Officers.*—(1) When the adjutant * * * and returns it to the ward officer. He also approves the clinical record, has prepared from it an abstract to accompany patient being transferred to other hospital, and then transmits the clinical record to the registrar **to be forwarded to the other hospital.**

* * * * * * *

[A. G. 062.11 (12-30-41).] (C 1, Mar. 31, 1942.)

96. Line of duty boards.—*a.* AR 345-415 directs that battle casualties, injuries received while operating or riding in Government vehicles or airplanes, and injuries received while on maneuvers, during authorized athletic exercises, or other-

wise while engaged in the execution of military duty, will be considered to have been incurred in line of duty, provided misconduct or gross negligence is not a contributory factor. In such cases not involving misconduct or gross negligence, the line of duty will be determined by the commanding officer or the next superior officer and the surgeon. In every case of injury, which in the opinion of the surgeon is likely to result in a partial or complete disability and eventually be made the basis of a claim against the Government, and which was incurred while on pass, furlough, leave, or as a result of misconduct or gross negligence, the commanding officer upon recommendation of the surgeon will convene a board of officers to investigate and report upon the circumstances attending the injury **(AR 345–415).**

* * * * * * *

[A. G. 062.11 (12–30–41).] (C 1, Mar. 31, 1942.)

98. Registrar.

* * * * * * *

b. Supervision of clerical work.—The registrar coordinates all matters relating to the discharge of enlisted patients on certificates of disability. He is responsible that the entries on the certificate of disability are correct and that upon completion of the discharge the certificate of disability and allied papers are disposed of as directed by section **II**, AR 615–360.

[A. G. 062.11 (12–30–41).] (C 1, Mar. 31, 1942.)

APPENDIX I

CHECK LIST FOR MEDICAL (HOSPITAL) INSPECTOR

2. Environmental sanitation.

* * * * * * *

b. Public buildings.

* * * * * * *

(4) *Bakeries.*

* * * * * * *

(*i*) Are towels or other cloths in use? (AR 40–205.)

* * * * * * *

d. Disposal of garbage, manure, dead animals, and other refuse.

* * * * * * *

(2) Is garbage collector permitted to transfer garbage from can to can during collections at kitchens, thus creating a polluted condition of the soil? (AR 40–205.)

* * * * * * *

e. Food supplies and their preparation.

* * * * * * *

(8) Is raw milk sold on the post? (Ch. XI, Army Medical Bulletin No. 23.)

* * * * * * *

(11) Is milk used on the post from cows giving a positive agglutination test? (Ch. XI, Army Medical Bulletin No. 23.)

* * * * * * *

(33) Are dish cloths in use? (AR 40–205.)

* * * * * * *

[A. G. 062.11 (12–30–41).] (C 1, Mar. 31, 1942.)

APPENDIX II

CHECK LIST FOR COMMANDING OFFICER OR SURGEON

23*f*. Helpless patients **are not** kept above second floor of hospital (AR 40–590).

[A. G. 062.11 (12–30–41).] (C 1, Mar. 31, 1942.)

37*e*. Are officers on duty at the hospital subsisted at the hospital mess? (AR 40–590.)

[A. G. 062.11 (12–30–41).] (C 1, Mar. 31, 1942.)

47. Are civilian physicians in Army hospitals authorized to sign official papers pertaining to military personnel? (Par. 8, circular letter No. 1, S. G. O., 1940.)

[A. G. 062.11 (12–30–41).] (C 1, Mar. 31, 1942.)

APPENDIX III

CHECK LIST FOR REGISTRAR

51. Injuries are reported as required (par. 10 *g* and *h*, circular letter No. 1, S. G. O., 1940).

[A. G. 062.11 (12–30–41).] (C 1, Mar. 31, 1942.)

APPENDIX IV

CHECK LIST FOR MEDICAL SUPPLY OFFICER

4*c*. Are issues made at any hour of the day or night if a request is made? (AR 40–590.)

[A. G. 062.11 (12–30–41).] (C 1, Mar. 31, 1942.)

7. Is an accumulation of nonstandard supplies on hand? (Circular letter No. 1, S. G. O., 1940.)

[A. G. 062.11 (12–30–41).] (C 1, Mar. 31, 1942.)

8. Is a record of surplus property kept? (AR 40–1705.)
[A. G. 062.11 (12–30–41).] (C 1, Mar. 31, 1942.)

12.

* * * * * * *

b. Is it customary to keep any of the narcotics or alcohol listed below stored in unit equipment?

* * * * * * *

d. Is a list of the above items kept in the equipment chests to avoid danger of delay or shortage when a unit takes the field?
[A. G. 062.11 (12–30–41).] (C 1, Mar. 31, 1942.)

17*d.* Do records show excessive exchange of biologicals? (Par. 64, circular letter No. 1, S. G. O., 1940.)
[A. G. 062.11 (12–30–41).] (C 1, Mar. 31, 1942.)

20. Are separate meters installed to record the electric current used for X-ray machines, centrifuges, and other such purposes?
[A. G. 062.11 (12–30–41).] (C 1, Mar. 31, 1942.)

39. Is hospital laundry put out to private laundries on contract or informal agreement? (AR 40–590.)
[A. G. 062.11 (12–30–41).] (C 1, Mar. 31, 1942.)

44*b.* Is there an accumulation of obsolete or damaged medical books? (AR 40–1705.)
[A. G. 062.11 (12–30–41).] (C 1, Mar. 31, 1942.)

45*b.* Was payment made from the hospital fund? (AR 40–590.)
[A. G. 062.11 (12–30–41).] (C 1, Mar. 31, 1942.)

APPENDIX V

CHECK LIST FOR DIRECTOR OF DIETETICS (MESS OFFICER)

2*h.* Are containers for poisons such as rat poisons, roach powders, etc., kept in the mess room? (AR 40–590.)
[A. G. 062.11 (12–30–41).] (C 1, Mar. 31, 1942.)

9*a.* Mess officer has copies of TM 10–405 **and 10–410.**

* * * * * * *
[A. G. 062.11 (12–30–41).] (C 1, Mar. 31, 1942.)

APPENDIX VI

CHECK LIST FOR COMMANDING OFFICER, MEDICAL DETACHMENT

23. Are enlisted men permitted to wear the white uniform when not actually engaged in an appropriate duty in the hospital? (AR 600–40.)

[A. G. 062.11 (12–30–41).] (C 1, Mar. 31, 1942.)

APPENDIX VII

CHECK LIST FOR PRINCIPAL CHIEF NURSE

19. Is it possible to grant annual leave to the nurses without crippling the service?

[A. G. 062.11 (12–30–41).] (C 1, Mar. 31, 1942.)

21. Are expenditures from the hospital fund made for furnishings for nurses' recreation rooms or for other purposes? (AR 210–50, and par. 15, circular letter No. 1, S. G. O., 1940.)

[A. G. 062.11 (12–30–41).] (C 1, Mar. 31, 1942.)

24. Does the principal chief nurse maintain a council book to account for moneys received from miscellaneous sources in violation of existing regulations? (Par. 15, circular letter No. 1, S. G. O., 1940.)

[A. G. 062.11 (12–30–41).] (C 1, Mar. 31, 1942.)

APPENDIX VIII

CHECK LIST FOR CHIEF OF SURGICAL SERVICE

2. Genito-urinary section.

* * * * * * *

f(2)(*b*) Are patients with gonorrhoea retained in hospital until satisfactorily cured?

* * * * * * *

[A. G. 062.11 (12–30–41).] (C 1, Mar. 31, 1942.)

4. Surgical wards.

* * * * * * *

h(3) Is soiled clothing of patients laundered at Government expense as a part of the hospital laundry? (AR 40–590.)

* * * * * * *

s(1) Dietitian and head nurse are responsible for the service of meals.

* * * * * * *

(9) Are attendants permitted to eat in the wards or diet kitchens?

* * * * * * *

[A. G. 062.11 (12–30–41).] (C 1, Mar. 31, 1942.)

APPENDIX XI

CHECK LIST FOR CHIEF OF DENTAL SERVICE

5. Are enlisted men assigned to dental service regarded as being on special duty and under special instruction, and not required to attend any other form of instruction? (AR 40–15.)

[A. G. 062.11 (12–30–41).] (C 1, Mar. 31, 1942.)

APPENDIX XII

CHECK LIST FOR CHIEF OF ROENTGENOLOGICAL SERVICE

6*l*. Are films stored in rooms which are shared with other activities?

* * * * * * *

[A. G. 062.11 (12–30–41).] (C 1, Mar. 31, 1942.)

APPENDIX XIV

CHECK LIST FOR OFFICER IN CHARGE OF PHARMACY

12. Have unduly large amounts of alcoholic liquors been prescribed at one time for any one person? (AR 40–590.)

[A. G. 062.11 (12–30–41).] (C 1, Mar. 31, 1942.)

22. Are prescriptions refilled without a written order calling for a refill by number? (TM 8–233.)

[A. G. 062.11 (12–30–41).] (C 1, Mar. 31, 1942.)

BY ORDER OF THE SECRETARY OF WAR:

G. C. MARSHALL,
Chief of Staff.

OFFICIAL:

J. A. ULIO,
Major General,
The Adjutant General.

U. S. GOVERNMENT PRINTING OFFICE: 1942

TECHNICAL MANUAL

FIXED HOSPITALS OF THE MEDICAL DEPARTMENT

(GENERAL AND STATION HOSPITALS)

CHANGES No. 2

WAR DEPARTMENT,
WASHINGTON, February 9, 1943.

TM 8–260, July 16, 1941, is changed as follows:

12. **Administrative service.**

* * * * * * *

f. Principal chief nurse.—The principal chief nurse has general supervision over all Army nurses on duty at the hospital, arranges the hours of duty, their assignment, and is responsible for their discipline both on and off duty. (She brings to * * * and app. VII).

* * * * * * *

[A. G. 062.11 (2–1–43).] (C 2, Feb. 9, 1943.)

36. **Messes for patient officers.**—The director of dietetics causes a separate mess to be maintained for all patients on an officer status. Ambulant patients on an officer status on regular diets should be furnished table service.

[A. G. 062.11 (2–1–43).] (C 2, Feb. 9, 1943.)

37. **Nurses' funds.**—Rescinded.

[A. G. 062.11 (2–1–43).] (C 2, Feb. 9, 1943.)

BY ORDER OF THE SECRETARY OF WAR:

G. C. MARSHALL,
Chief of Staff.

OFFICIAL:
J. A. ULIO,
Major General,
The Adjutant General.

512105°—43

U. S. GOVERNMENT PRINTING OFFICE: 1943